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UNITED STATES
DEPARTMENT
OF LABOR
FRANCES PERKINS
Secretary

CHILDREN'S
BUREAU
KATHARINE F. LENROOT
Chief



Bureau
Publication
No. 258

Services for Crippled Children

Under the Social Security Act

Development of Program, 1936-39

UNITED STATES
GOVERNMENT
PRINTING OFFICE
WASHINGTON : 1941

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Title V, Part 2

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U. S. SUPERINTENDENT OF DOCUMENTS

JUL 18 1941

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LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, December 18, 1940.

MADAM: There is transmitted herewith Children's Bureau Publication No. 258, Services for Crippled Children Under the Social Security Act; development of program, 1936-39. This bulletin includes a description of the cooperative Federal-State program for services for crippled children made possible by Federal grants to the States under title V, part 2, of the Social Security Act (1935).

The Federal phases of the program have been administered by the Crippled Children's Division, Robert C. Hood, M. D., Director, under the supervision of Martha M. Eliot, M. D., Assistant Chief of the Children's Bureau.

Respectfully submitted,

KATHARINE F. LENROOT, *Chief.*

HON. FRANCES PERKINS,
Secretary of Labor

Services for Crippled Children

Under the Social Security Act

Development of Program, 1936-39

The year 1936 marked the beginning of a new stage in the care of crippled children in the United States. Federal grants for services for crippled children under the Social Security Act (approved August 14, 1935),¹ totaling approximately \$732,500, went to the States for expenditure during the 5-month period ending June 30, 1936.

The growth of medical science during the past 75 years and the development of orthopedic and plastic surgery brought the possibility of physical restoration to many children suffering from crippling conditions. The efforts of private individuals and physicians treating crippled children had built up a system of hospital service and community assistance for the care of crippled children that led first to State action and in 1935 to Federal action to provide funds for services for crippled children.

The White House Conference on Child Health and Protection (1930) gave impetus to the growing movement through its evaluation of services available in the United States for the care of crippled children and of educational services available for handicapped children. Its report, in addition to recommendations on the education and vocational placement of crippled children, called for legal authorization for a program to find crippled children, to provide expert orthopedic diagnosis and proper facilities for hospitalization and medical care, and to establish a Federal program of research in behalf of crippled children, including a national bureau of information that could also distribute Federal money to State services for crippled children.²

Testimony presented before the President's Committee on Economic Security in 1934 and before congressional committees in 1935 showed that by 1934 some provision had been made in 37 States for a State department or commission or a State hospital to provide medical

¹ 49 Stat. 620.

² White House Conference on Child Health and Protection: *The Handicapped Child*, pp. 177-178. Century Co. (now D. Appleton-Century Co.), New York, 1933.

treatment and hospital care for crippled children, and 35 of these States had made appropriations for this purpose. In only a few States, however, were sufficient funds available to carry on broad programs, including the finding of crippled children throughout the State and providing diagnosis, medical and surgical treatment, and aftercare services for such children.

The Social Security Act as approved August 14, 1935, included authorization for an annual appropriation of \$2,850,000 for grants to the States to enable each State to extend and improve services for crippled children, especially in rural areas and in areas suffering from economic distress. Federal funds for grants to the States for this purpose were made available in February 1936. The Children's Bureau of the United States Department of Labor was made responsible for the administration of this part of the Social Security Act.³

The program thus inaugurated was the first instance of Federal and State cooperation in providing medical care involving Federal grants to the States. The policies and procedures developed for carrying on the crippled children's program deserve close study from many standpoints. Among these are: (1) The relationships of the Federal administrative agency to the State crippled children's agencies; (2) the relationship of the State agency to other State and local public agencies and institutions giving some form of service to crippled children; (3) the development of cooperative relationships with private agencies serving children or seeking service for crippled children; (4) the selection and training of the staff of the State crippled children's agency; (5) the protection of the quality of care made available for crippled children through the development of standards for the selection of physicians, surgeons, and other professional workers in private practice engaged to give treatment to crippled children and through the adoption of standards for the choice of hospitals, convalescent homes, and foster homes to which children are sent for care; (6) the development of community resources for providing care for crippled children who do not need to be hospitalized; and (7) the development of after-care services to meet the health and social needs of the child who has been given medical treatment.

In 1938 the Interdepartmental Committee To Coordinate Health and Welfare Activities submitted to the President and to the public the report of the Technical Committee on Medical Care proposing a national health program. The Committee included among its recommendations the expansion of the program for crippled children, under part 2 of title V of the Social Security Act, to provide within 10 years \$10,000,000 annually for services for crippled children, of which one-half, or \$5,000,000, would be the Federal contribution.

³ For the text of part 2 of title V of the Social Security Act, providing for grants to the States for services for crippled children, see appendix, p. 92.

The Social Security Act Amendments of 1939, approved August 10, 1939, opened a new period in the development of services for crippled children by raising to \$3,870,000 the annual amount authorized for Federal grants to the States and by providing that of this amount \$1,000,000 would be allotted, without a matching requirement, on the basis of the financial need of each State for assistance in carrying out its State plan, after consideration of the number of crippled children in need of service and the cost of service. Except for limited payments to some States the additional grants under this authorization were made to the States after January 1, 1940. This publication deals with the development of the program of services for crippled children under the Social Security Act as passed in 1935.

The Social Security Program for Crippled Children

According to the terms of the Social Security Act of 1935, the Secretary of Labor allotted to the States the annual appropriation on the basis of \$20,000 to each State and the remainder according to the need of each State as determined after consideration of the number of crippled children in each State in need of service and the cost of furnishing service. These funds under the 1935 act were made available for payment of half the total expenditure under approved State plans; that is, matching by State and local funds was required. Funds allotted to a State in any year remain available for payment until the end of the second succeeding fiscal year. Payments to the States are made in accordance with State plans for services for crippled children submitted to the Chief of the Children's Bureau and approved when they are in accord with the requirements of the act.⁴

The States promptly took the necessary action to take advantage of the cooperation offered by the Federal Government. Most of the States found it necessary either to create an official crippled children's agency to administer the crippled children's program or to reorganize and strengthen an existing public agency. By June 30, 1937, every State⁵ had designated a State agency to administer crippled children's services. By March 24, 1939, every State had obtained the approval of the Chief of the Children's Bureau, as required by the act, for its State plan for services for crippled children and was matching in whole or in part the Federal funds offered for this purpose.

The steady expansion of the program is shown by the increase in Federal payments to the States for each fiscal year. As the Federal

⁴ For the terms under which the Federal grants to the States for services for crippled children are made see the text of part 2 of title V of the Social Security Act, (appendix, p. 92). See also Children's Bureau Publication No. 253, Grants to States for Maternal and Child Welfare Under the Social Security Act of 1935 and the Social Security Act Amendments of 1939 (Washington, 1940).

⁵ The term "State" includes Alaska, Hawaii, and the District of Columbia.

grants were matched by State expenditures for services for crippled children, the total expenditure each year was at least twice the Federal payments. The total expenditure—Federal and State—for the fiscal year 1939 amounted to approximately \$6,000,000. Amounts paid on the basis of approved plans for the fiscal years ended June 30, 1936, 1937, 1938, and 1939, are shown in table 1, page 5.

The Children's Bureau of the United States Department of Labor, as the Federal agency designated to administer the crippled children's provisions of the Social Security Act, consults with State agencies in the development of their programs, brings to them the advisory service of nationally recognized leaders in the professions involved, who serve as members of advisory committees to the Children's Bureau, and makes possible an exchange of experience among the States in the handling of the various problems that arise in administering the services. The present bulletin includes a summary of developments for the country as a whole for the years 1936-39, and brief summaries written by the State administrators at the close of the fiscal year ended June 30, 1938.

The Social Security Act (title V, part 2) describes in general terms the purpose for which the Federal grants are to be used—to enable each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children and for providing medical, surgical, corrective, and other services and care and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions that lead to crippling.⁶

The plan for services for crippled children submitted by the official State agency to the Children's Bureau is required by the act to include provisions for such methods of administration as are necessary for the efficient operation of the plan, and provisions for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in the State administering State laws providing for vocational rehabilitation of physically handicapped children. The two provisions just cited impose upon the Federal administrative agency, the Children's Bureau, and upon the State crippled children's agencies responsibility for seeing that the program is well administered from the standpoint of service to children and that cooperation is maintained with the professional groups and other agencies that are concerned with these services.

⁶ For a more extensive description of the administrative development of the Federal-State program of services for crippled children, see sections on Federal Administration and Services for Crippled Children in Children's Bureau Publication No. 254, *Federal and State Cooperation in Maternal and Child-Welfare Services Under the Social Security Act* (Maternal and Child-Welfare Bull. No. 2), Washington, 1938.

Table 1.—Federal payments to States for services for crippled children under the Social Security Act, title V, part 2, for the fiscal years ended June 30, 1936, 1937, 1938, and 1939

State ¹	Federal payments under approved State plans			
	Fiscal year 1939	Fiscal year 1938	Fiscal year 1937	Fiscal year 1936 (Feb. 1-June 30)
Total.....	\$2,997,914.77	\$2,691,869.82	\$2,011,606.04	\$732,492.33
Alabama.....	73,994.89	78,000.00	37,442.61	17,846.21
Alaska.....	6,424.62	4,925.19	2,115.62	1,250.00
Arizona.....	37,211.05	38,203.22	21,662.74	10,608.00
Arkansas.....	90,450.01	52,943.32	-----	-----
California.....	101,230.83	115,700.99	33,731.23	13,758.00
Colorado.....	59,374.59	21,979.97	48,794.60	9,500.00
Connecticut.....	17,976.69	33,735.60	-----	-----
Delaware.....	4,979.27	4,349.16	-----	-----
District of Columbia.....	44,428.97	34,201.66	663.32	5,586.68
Florida.....	58,218.54	57,792.89	57,494.66	15,495.00
Georgia.....	93,711.13	22,193.49	4,993.75	-----
Hawaii.....	23,339.95	14,050.29	15,816.03	-----
Idaho.....	23,475.41	21,629.89	18,216.52	8,000.00
Illinois.....	179,890.07	135,328.57	4,900.00	-----
Indiana.....	70,298.78	31,134.75	26,411.65	-----
Iowa.....	57,576.94	68,679.47	58,776.94	-----
Kansas.....	56,209.12	44,996.80	36,810.00	9,726.64
Kentucky.....	85,000.00	83,038.28	82,267.04	26,520.10
Louisiana.....	35,000.00	-----	-----	-----
Maine.....	36,940.49	32,489.44	25,465.72	12,057.36
Maryland.....	61,861.06	48,404.58	36,033.56	-----
Massachusetts.....	83,052.23	84,667.70	61,591.71	21,233.00
Michigan.....	100,000.00	97,819.20	99,999.99	37,000.00
Minnesota.....	73,583.02	62,599.86	95,161.00	14,379.00
Mississippi.....	34,654.91	34,851.39	12,606.40	2,487.08
Missouri.....	62,404.98	60,980.00	53,629.83	24,598.00
Montana.....	45,270.46	30,069.88	18,869.93	7,900.00
Nebraska.....	51,163.92	55,775.46	16,552.38	25,000.00
Nevada.....	999.99	1,000.00	-----	-----
New Hampshire.....	11,229.59	11,884.74	2,500.00	1,500.00
New Jersey.....	79,723.44	50,906.47	86,711.66	37,494.88
New Mexico.....	24,241.98	48,904.58	27,089.28	7,500.00
New York.....	117,661.54	120,308.46	74,162.72	61,213.00
North Carolina.....	96,537.05	84,710.10	72,789.71	32,086.00
North Dakota.....	28,493.67	45,185.12	11,728.44	-----
Ohio.....	121,497.06	138,786.07	158,701.76	44,650.00
Oklahoma.....	77,543.52	93,986.16	61,825.00	21,508.33
Oregon.....	24,379.70	24,257.50	-----	-----
Pennsylvania.....	163,267.70	131,929.79	106,609.05	55,639.00
Rhode Island.....	22,157.24	34,545.75	5,000.00	3,000.00
South Carolina.....	64,412.09	47,169.24	37,863.00	8,300.00
South Dakota.....	23,540.17	29,798.78	26,551.77	12,010.74
Tennessee.....	45,986.87	35,914.27	21,947.75	25,593.00
Texas.....	122,191.76	119,074.85	152,717.75	49,999.92
Utah.....	29,999.98	29,999.99	29,999.99	7,500.00
Vermont.....	18,409.87	19,233.11	12,217.40	6,665.00
Virginia.....	72,040.08	70,663.25	73,297.33	21,672.57
Washington.....	54,540.00	50,516.42	43,923.40	14,915.00
West Virginia.....	53,672.75	69,121.97	80,330.10	26,268.27
Wisconsin.....	69,475.00	59,843.66	49,508.55	22,258.63
Wyoming.....	8,191.79	3,588.49	6,124.15	9,772.92

¹ The term "State" includes Alaska, Hawaii, and the District of Columbia.

In the development of this Nation-wide program for the care of crippled children valuable experience has been accumulated showing how public-health and public-welfare agencies, physicians, and public and private hospitals, under State programs, with Federal participation, collaborate in furnishing medical care and how the quality of care given in such a program may be safeguarded.

The Children Receiving Service

An account of the crippled children's program would not tell the whole story without some presentation of the letters that come from crippled children and from their parents, revealing the need for medical care, the distress of the parents and the child when the family cannot pay for the care needed, and the fresh hope and courage that come to the child when treatment has improved his condition. Since the inauguration of the social-security program, these letters coming from the States are being referred to the State crippled children's agencies with assurance that the child's condition will be diagnosed, and in the majority of cases remedial treatment can and will be given.

The following letters have been selected from hundreds that come to the Children's Bureau or are referred to the Bureau each year. They illustrate some of the many problems associated with medical care and aftercare, with which the State agency helps the child and his family to cope.⁸

I have had that dreadful disease, infantile paralysis. I can't walk without the use of crutches. I get very lonely watching other children play since I can't run and play like other children. I don't believe anyone would be happier than I, if I could walk. * * * You can't realize how much I will appreciate it if there is anything you can do.

I am a poor man, the father of five children, and out of work. I have a crippled daughter aged 15. She walks one mile to school every day on a crippled leg. It is very painful at times. * * * Will you please have the doctors straighten her leg? I don't want my child to be a cripple all her life. She would be so happy if she could walk like other girls.

* * * It is said I can walk perfect some day. I do not have to use my braces and crutches any more, but I walk with a limp. Mother and Dad are very poor and cannot afford to send me to the hospital for proper care. I can be cured if I get the proper treatment which we cannot afford. * * * I am 15 years old and go to high school. Pretty soon I will have to help support the family. I know that if I were cured I'd have a much better chance to get a job in the business world.

I am writing to ask for help. I really need it because my father works on W. P. A. and makes only \$39.00 a month. He has to pay house rent, \$12.50, and

⁸ These letters have been changed in certain particulars so that the actual story of any child is not told.

feed four in the family. My mother is not well. She has to stay home and take care of me as I am crippled and have been for 4 years with osteomyelitis. I do not get nearly enough nourishing food to eat. My father is providing the best he can and that doesn't half supply me. I need milk, food, and something to dress my wound with. It has to be dressed twice a day. I am not sick enough to be in the hospital for that. Home and clinic service is better for me than hospital care. My father has no way of taking me to and from the clinic as often as my leg needs to be dressed. I haven't had cod-liver oil in 6 weeks, although the doctor said I should have it every day. Surgery has my leg improving, but without food I can't make it. During the snow, I was cold and caught cold in my leg because of no fire. I am 15 years of age. I would also like to have some schooling to keep my mind busy.

* * * If she were incurable I might be able to reconcile myself but such a little thing is wrong. The heel cord of her right leg is paralyzed and has not grown. That little leg is shorter and often pains her severely. She cannot run, she limps badly and often stumbles and falls. She will only grow worse with time. Yet several doctors have said she could probably be cured if she could have the benefit of hospitalization, hydrotherapy, and the services of an expert orthopedic doctor. * * * My husband manages to make enough to keep us off the relief and that is all. * * * But I am not too proud to ask for help for my baby. I didn't suppose there was any use until recently I have been told that the Social Security Act provided for operations for the cure of crippled children.

Many letters come back to the Children's Bureau, reporting on the results of investigation of appeals and of treatment given crippled children. A mother wrote:

* * * My child was born with a double harelip and cleft palate and has already gone through two operations. He is ready to go through the third and we have not money for it.

Within 2 months the answer came back:

Dr. ——— reported by letter that the baby is to return to ——— Hospital at an early date.

Again:

We were very happy over our son. And then the time came when we found out that our son is paralyzed on his right side. He limps a little and cannot use his right arm. * * * He is such a fine, straight, and tall boy, 9 years old and bright—in the 4th grade in public school.

A year later the report came back:

This patient was admitted to the State hospital and is now ready for discharge * * * The right arm was treated by placing the shoulder and arm in a plaster cast. Later both the arm and foot responded very well to physiotherapy, and surgical procedure was found to be unnecessary. The patient's condition is markedly improved.

It is not always that the end of the story can be satisfactory. The State agencies for the most part must use their limited funds for the care of crippled children for whom some substantial degree of physical

restoration is possible. For some conditions custodial care from some other source is all that can be provided. In some States the legal definition of crippled child is so limited that treatment cannot be given to children above a fixed age limit or to those disabled from conditions not included in the law—conditions that might be covered in another State. Again the amount of crippled children's funds or the hospital facilities may be so limited that there is delay between diagnosis and treatment. However, thousands of crippled children are being given treatment each month because of Federal-State cooperation under the Social Security Act.

Organization of State Agencies

The earlier State programs for crippled children under the Social Security Act had been placed under welfare departments, education departments, health departments, or independent commissions, depending on the emphasis given by the State group through whose efforts the first legislation or appropriation was obtained. Before the passage of the Social Security Act medical-care services of various types assumed by the States had been most commonly associated with hospital or institutional care of the sick and the physically and mentally handicapped, and were usually administered by State welfare departments. Health departments, State and local, had sometimes been given responsibility for medical care for persons suffering from communicable diseases.

With the development of public-health services made possible by Federal grants under the Social Security Act, State health departments were strengthened, many more local full-time health units were organized, and maternal and child-health services and other preventive health services were greatly extended. Associated with these developments there has been an increasing tendency to place upon the public-health agency the responsibility for the crippled children's program.

By December 1939 the official crippled children's agencies designated by the States were as follows: The department of health in 26 States; the department of public welfare in 14 States; a crippled children's commission in 5 States; the department of education in 5 States; and a university hospital in 1 State.

That the program for crippled children is primarily one of medical care is recognized in the selection of those who compose the professional staffs of the State agencies—orthopedic surgeons, pediatricians, other medical specialists, public-health nurses, medical-social workers, and physical-therapy technicians. A count in December 1939 showed that in 35 States physicians were serving as directors of the program and in 4 States physicians were serving as assistant directors.

In the local phases of the program—locating crippled children, conducting diagnostic and treatment clinics, and supervising aftercare services in the home—the State crippled children's agencies receive the assistance of local health departments, welfare departments, and school authorities.

The principal responsibilities of the State crippled children's agencies are: (1) To locate children in need of care and to maintain a State register of crippled children; (2) to arrange for the diagnosis and treatment of crippled children at permanent clinic centers or, in sections of the State where there are no permanent centers, at itinerant clinics; (3) to arrange for surgical and medical care by orthopedic surgeons and physicians at selected hospitals; (4) to arrange for treatment and care for children living at home, who do not need operative care or treatment in a hospital; (5) to place children, when necessary, in convalescent homes or foster homes; (6) to provide or arrange for physical-therapy treatments when indicated, after the child has returned home; (7) to provide public-health-nursing and medical-social services to the family for the purpose of continuing the care of the child and helping him to make a social adjustment in the family, at school, and in the neighborhood; and (8) to refer the child for training to the State vocational-rehabilitation service.

To provide the necessary procedures for carrying through such a program was the first administrative task of the State crippled children's agencies. Those with several years of experience had an advantage, but for most the social-security funds made possible either a new program or a much more complete and extensive program than had existed before these funds became available.

The Children's Bureau, through its Crippled Children's Division and its orthopedic, medical, public-health-nursing, and medical-social consultants and through conferences of State directors of crippled children's services, aids in developing administrative procedures. The Children's Bureau Advisory Committee on Services for Crippled Children, the conference of State and Territorial health officers, and State advisory committees on crippled children's services have given advice throughout this period of rapid development.

The State director of the crippled children's program is responsible for the organization and administration of services to crippled children, and for maintaining cooperative relationships with other agencies, public and private, that are concerned with one phase or another of the crippled children's program.

The State agency is responsible for maintaining the quality of medical care. This responsibility involves the development of standards for the selection of professional personnel and of hospitals, and the dissemination of information regarding the prevention

and early treatment of crippling conditions or conditions that may lead to crippling. Owing to the fact that the crippled children's program is one involving numerous problems requiring decisions of a medical nature, some of the State agencies have found it desirable to employ a physician with training and experience in either public-health work or pediatrics to serve as director of the program. In a few States an orthopedic surgeon serves as director or consultant on the State staff. A few State agencies also have employed pediatric consultants to advise on the general medical care of children.

Public-health nurses and medical-social workers on the State staff serve as consultants in their respective fields in the development of the State program and in the supervision of the local phases of the program.

Certain local administrative duties—such as receiving the names of crippled children to be examined, arranging for clinic sessions, and handling the necessary admission, discharge, and aftercare procedures—are performed by local public-health personnel in some States and by local welfare workers in others. For such duties it is customary for the crippled children's agency in the State health department to use local health units and for the crippled children's agency in the State welfare department to use local welfare departments. Regardless of where the initial administrative responsibility rests, it is becoming the accepted practice for the local public-health agency, if it is in charge of the local program, to request the local welfare agency to investigate the social factors to be considered in arranging for the care of the crippled child, and for the welfare agency, if it is in charge of the local program, to call on the local public-health agency to arrange for the health phases of the provision for the crippled child. The State supervising nurse and the medical-social worker advise the local workers on the health and social phases of the program.

The local public-health nurse increasingly is including the care and health supervision of crippled children in her general family health service in the home. Trained to recognize slight deviations from the normal, the public-health nurse is in a position to bring to the attention of parents the need of medical care for the slight clubfoot, for the limp that may be due to congenital dislocation of the hip, or for some other restricted use of the arms or legs. Her close and frequent association with the families through her work in the home, in the school, and at the clinic gives her the opportunity to explain the various phases of the crippled children's program and, if it is necessary, to convince the parents of the advisability of bringing the child to the diagnostic clinic. During visits in the home she may explain the mother's responsibility for eliminating hazards in the home that

may cause falls and burns which may result in crippling. She may explain also the need for teaching children to safeguard themselves, the importance of prompt medical care, and the home care that is needed for minor injuries.

To make possible effective cooperation in the crippled children's program on the part of the nursing staff of State and local health agencies, the nurse on the staff of the State crippled children's agency frequently serves as consultant in orthopedic nursing for the division of public-health nursing in the State health department. In this capacity she is responsible for staff-education programs in orthopedic nursing and, with the supervisor of local public-health nursing, plans the emphasis that the crippled children's service should have in the local nurse's program, to the end that adequate nursing supervision and care shall be given to all crippled children.

Similarly, in several States the medical-social worker on the staff of the State crippled children's agency is in a position to serve in a liaison capacity between the State crippled children's agency and the State public-welfare agency and to assist in the instruction of county or local welfare workers in regard to the phases of the crippled children's program in which their services are needed. The medical-social consultant can develop procedures with the State welfare agencies so that the local welfare worker may furnish to the State crippled children's agency social information that is pertinent in the care of crippled children. The local welfare worker frequently has the opportunity to bring to the attention of parents of a crippled child the diagnostic and treatment services that the State agency can provide. Her advice is needed frequently to help in working out a social situation in the home that is impeding the medical treatment or the progress of a crippled child.

In the early stages of the crippled children's program in many States it was necessary to have the State public-health nurse or the medical-social worker give direct service to children in many areas of the State. With the development of local health and welfare services, it is increasingly becoming possible to call on the local public-health nurse and welfare worker for work with individual children, thus freeing the State workers for consultation and educational services.

A physical-therapy technician of the State staff in a few States supervises the physical-therapy treatments given under medical direction to children at home and the physical-therapy instruction given to public-health nurses and to parents. Because the number in local areas is limited, some of the State agencies have found it necessary to employ physical-therapy technicians and place them in districts to give direct service to crippled children, in addition to giving instruction to nurses and parents.

Registration of Crippled Children

The registration of crippled children is a basic service essential to the determination of the scope of the program. It is the first step in arranging for the care of the individual child.

The initial surveys conducted cooperatively by public and private agencies have led to more systematic and continuous registration procedure under the leadership of the State crippled children's agencies. The schools have long given assistance in finding crippled children, not only children of school age but also younger children. Provision has been made in a few States for current reports from the schools to the State crippled children's agency or, at its direction, to a cooperating local agency.

With the rapid development of the local health departments and welfare departments during the past few years, the public-health nurses and the welfare workers who visit families in their homes assist the State crippled children's agency in carrying on a continuous inquiry to find crippled children in need of care.

Arrangements have been made in the majority of the States to have epidemiological reports of children affected by infantile paralysis come systematically into the office of the State crippled children's agency. In a steadily increasing number of States information on congenital abnormalities or birth injuries is being recorded on the birth certificates, and this information is transmitted by the State health department to the State crippled children's agency for prompt follow-up. At the request of the Children's Bureau, the United States Bureau of the Census, on January 12, 1939, sent out with its standard birth certificate a list of optional items for recording this information.

Usually it is easier to find crippled children in the cities than in rural areas. However, it has been found that the people in rural areas readily cooperate in reporting crippled children in need of care when they know about the services for crippled children offered by the State agency and know the steps to be taken in referring a child for care. The State crippled children's agencies are developing information services designed to reach all parts of the States and especially the local officials and groups that can be most helpful at this stage of the program.

In 1936 the Children's Bureau submitted to the State agencies forms for quarterly reports on the registration of crippled children. In 1938 an outline of points to be observed in establishing a State register of crippled children was sent out, and in 1939 a simplified form for quarterly reports of crippled children on State registers was issued. A guide for recording the diagnosis of crippling conditions based on the Standard Classified Nomenclature of Disease was sent

to the States in 1937 and a similar guide in expanded form was issued in 1938. The purpose of such a record system is to promote essential uniformity and completeness of records within each State and for all the States. In 1938 the Children's Bureau obtained from the State agencies special reports on the sex, race, age, and diagnosis of crippled children on the State registers.

Each year the records are becoming more nearly complete and are yielding more reliable information on the number of crippled children in the United States and on the character of the crippling conditions from which they are suffering.

The State registers of crippled children are not limited to children accepted for care by the State agency. It is intended that these registers shall include *all* persons under 21 years of age, living in the State, who are suffering from crippling conditions as determined by a licensed physician under the definition given in the State law or regulations, regardless of their economic status, their need for medical care, or the availability of treatment. When completed the registers will provide a dependable answer to the question frequently asked, "How many crippled children are there in the United States?"

Admission Procedure

For each child to be given service by the crippled children's agency it is necessary to arrange for a diagnosis. In the centers where diagnosis is made at permanent clinics at frequent intervals the State agency often arranges with a local cooperating agency to have the child brought in at an early date, or the State workers arrange with the parents or others to bring the child to the clinic.

In rural areas where clinics are held at less frequent intervals the names of children listed for diagnosis are held until the day for the clinic is set, and then arrangements are made for bringing the children in for examination. In cases where immediate examination is necessary, arrangements are made frequently to bring the child to the nearest permanent clinic or to the office of the nearest orthopedic surgeon.

The initial diagnosis is made under the authority of the State crippled children's agency by an orthopedic surgeon, usually at a permanent clinic or at a special clinic session arranged for outlying areas by the State agency. Increasingly, under the supervision and with the aid of the public-health nurse and the medical-social worker on the State staff, the local nurse and welfare worker assist in gathering the medical and social history essential to planning for the care of the child.

The admission procedure is a crucial point in the crippled children's program from the standpoint of determining the child's need

and arranging for care. It is necessary to make clear to the parents and to the child what can and should be done and how the State agency can provide the care that will benefit the child.

During 1937 the Children's Bureau made studies of intake procedures in several States. As a result of these studies, intake procedures have been clarified and improved by the State agencies.

Conducting a Crippled Children's Clinic

The experience of the past 3 years has resulted in the development of certain principles and procedures for the successful handling of a crippled children's clinic. These principles may be summarized as follows:

It is important to have a representative of the State agency or a responsible person in the local health or welfare unit make plans for the clinic well in advance of the day the clinic is to be held. The cooperation and interest of local physicians and of the county medical society should be enlisted from the start. Suitable notices of the clinic should be sent to the individuals and groups directly concerned. The children to attend should be selected on some well-defined basis such as children most urgently in need of diagnosis and care. The number should be limited to give the orthopedic surgeon and other specialists time for thorough examinations. Not more than 50 children, depending on the types of cases, should be seen by each examining orthopedist at an all-day clinic with sessions morning and afternoon.

The families should be notified when the child is to be brought to the clinic, and frequently transportation must be arranged. Lay workers should be asked to assist in arranging for transportation and for luncheon for children and parents who remain through the luncheon hour.

It is desirable to have the clinic held in a local hospital, when possible, either in a public hospital or in a hospital to which the State agency sends children for care. A hospital will usually have clinic facilities available and diagnostic aids such as X-ray. The clinic preferably should be on the first floor to make it unnecessary to carry crippled children upstairs.

At the entrance a receptionist, preferably the local public-health nurse who is known to those attending the clinic, directs the parents and crippled children to the waiting room and explains the service that is to be given. The receptionist should be able to recognize symptoms which may indicate a communicable disease, to answer questions with regard to the service, and to put parent and child at ease.

The clinic should have a sufficiently large waiting room, a portion of which may be screened off for interviewing parents prior to the examination of the child by the orthopedic surgeon. There should be at least two examining rooms, well-lighted and not too cramped, and a third room for dressing. There should be adequate facilities for the surgeons and physicians to scrub their hands between examinations, and toilet facilities should be near the waiting room.

The personnel conducting the clinic should include an orthopedic surgeon, a plastic surgeon, a pediatrician, the State orthopedic-nursing consultant, a medical-social consultant, a physical-therapy technician, and clerical assistants as needed. State agencies should arrange to have present at the clinics a representative of the State vocational-rehabilitation service.

The medical-social worker and the public-health nurse assist in obtaining the social and medical history of the crippled child on admission. A lay assistant may take the parent and child to the dressing room and aid in preparing the child for examination. Drapes are provided for the children, especially for the older girls.

The pediatrician should give a general physical examination and record his findings and recommendations on the chart that goes to the orthopedist. A public-health nurse should assist the pediatrician and should give him the additional information available about the child. The physical-therapy technician should test the muscle response of the child.

The orthopedic or plastic surgeon should make the examination of the crippling condition affecting the child. The surgeon and the peditrician should confer regarding the future care of the child. The State and local public-health nurse, the State medical-social worker, the local welfare worker, and the physical-therapy technician should also be available to confer with the surgeon in planning for the care of the child. After the surgeon has completed his examination, the child is returned to the dressing room.

It is particularly important that the recommendations of the orthopedist and the peditrician be clearly interpreted to the parents and that any plans for the future care of the child be clearly outlined so that there will be no confusion as to the immediate steps to be taken. Space should be reserved at the clinic so that the interviews with the parents can be held in private. The orthopedic surgeon should discuss with the parents the care needed for the child. Whenever the child is to be accepted for care by the State crippled children's agency, it is necessary for a medical-social worker to learn the attitude of the parents toward the proposed treatment, the conditions in the home affecting the child's care, and the financial resources of the family. On the basis of this information, decisions can be made as to the extent to

which the State will need to give assistance and as to the plan for hospitalizing the child or for carrying out any other recommendation which may have been made by the orthopedist, such as the purchase of an appliance.

In some States, following the clinic session, the physician in charge holds a conference with the other professional workers to review the record of each child and to decide upon the follow-up responsibility to be assumed by each worker.

When it has been decided that a child in need of care does not come within the scope of the State crippled children's program, the medical-social worker should advise the parents regarding the appropriate agency to which they may turn for assistance.

Reports from the State crippled children's agencies for the year ended June 30, 1939, showed marked progress in the development of clinics for the diagnosis and treatment of crippled children. Clinic sessions were held regularly in 359 permanent clinic centers, and 519 itinerant clinics were held at various points in the States.

The number of itinerant clinics held for diagnostic service only was 442 and the number held for both diagnosis and treatment was 64. Orthopedic surgeons were present at all clinics. At only 46 of the itinerant clinics was there a pediatrician in attendance. Local physicians attended the majority of the clinics and in 8 States local physicians assisted with the general physical examinations of the children.

Services for Children Not in Need of Hospitalization

Large numbers of crippled children examined in diagnostic clinics do not need hospital care, although they need medical supervision and other services. Generally speaking, only about 25 percent of the children with orthopedic and other crippling conditions examined at clinics are recommended for hospitalization. About 75 percent are in need of services that can be given while they are living at home. The latter is a difficult group to treat as these children are scattered and are frequently far away from the medical centers where out-patient treatment can most readily be given. The State agencies recognize the special needs of this group and are endeavoring to make more adequate services available for them, such as treatment clinics, physical therapy, public-health nursing, and social service.

Administrative problems involved in providing medical care and auxiliary services for this group of children are similar to those involved in providing aftercare services for children who have had a period of hospital care.

Arranging for Hospital Care

If the surgeon recommends medical or surgical treatment involving hospitalization, arrangements must be made as promptly as possible for admission to a hospital. When the diagnostician can foresee the probable length of hospitalization and convalescence, his opinion is basic in making financial arrangements and in preparing the family and the child for the period of separation. Careful explanation to the parents and the child by the surgeon, followed up by the nurse and the medical-social worker, is important in obtaining the active cooperation of the family and of the child in the treatment to be given.

The State agency assumes the responsibility for hospitalization and medical care on the basis of the examining physician's recommendation and the social investigation. The State agency refers the child to the surgeon or physician who is to take charge of the treatment and designates the hospital to which the child is to go. As soon as a bed becomes available, the parents are notified and arrangements are made for the transportation of the child to the hospital. Increasingly the medical and social data accumulated by the State agency in advance of hospitalization are being made available to the surgeon in charge.

In the few States in which county funds are used to pay for the care given crippled children, the county court commits the child either to the State crippled children's agency or to a State hospital for care. The commitment procedure in such States varies even between counties. Studies made by the Children's Bureau found procedure generally to be informal in character, and frequently without provision for giving the judge the estimated costs of medical care or social and economic data on which to base his decision as to the child's eligibility for public care. In some of these States the State agency is arranging to provide to the judge, through local workers, all available information that will be of assistance to him in making his decision.

Study of admission procedures points to the desirability of placing in one agency, the State crippled children's agency, both the responsibility for determining the need of care and the provision of that care. The Children's Bureau Advisory Committee on Services for Crippled Children at its December 1938 meeting recommended that the State crippled children's agencies assume final administrative responsibility for determination of eligibility for care and seek to eliminate court-commitment procedures.

The Crippled Child in the Hospital

A major responsibility of the State crippled children's agency for the care of the crippled child who needs medical or surgical treatment or both in the hospital is the selection of a competent physician or

surgeon and of a well-equipped and well-run hospital. Hospitals are selected in different parts of the State so that care may be given as near as possible to the child's home.

The kind of treatment given the child is the professional responsibility of the physician or surgeon in charge. The increase in the numbers of crippled children given treatment in all parts of the country and the increased numbers of various types of conditions accepted for treatment provide a volume of medical experience that gives promise of distinctly advancing medical knowledge of crippling conditions and methods of treatment.

The crippled children's program will benefit steadily from results obtained in research as to the prevention of diseases that cause crippling conditions and as to the means of preventing crippling in case these diseases occur.

Many State crippled children's agencies have had the assistance of advisory committees in working out payments for medical and surgical service and for hospital care. Surgical and medical fees have been agreed upon that take into account the time required, the responsibility involved, the special technical skill required for the treatment of crippled children, the total amount of funds available for all service, and the number of children to be accepted for care. Through conferences with hospital administrators agreements are reached on hospital charges to provide the quality of care necessary for this type of service. The tendency is to arrange for hospital charges on the basis of a flat rate covering all essential services except surgeon's fees and appliances, based on the average cost of ward care of crippled children for both acute and chronic conditions.⁹ More satisfactory methods of uniform cost accounting in the hospitals are needed, and these are being developed in accordance with uniform accounting practices recommended by the American Hospital Association.

The problem of the length of stay in the hospital directly affects the number of children who can be cared for, as this stage of treatment is the most expensive. Information as to conditions in the child's home and the extent to which aftercare service is available in the convalescent home, in the foster home, or in the community after the child returns to his own home is important for the physician or surgeon to have in making his decision as to when the child is ready to leave the hospital.

Planning for Aftercare

Planning for the aftercare of the child in advance of his discharge from the hospital is essential if the benefit of the surgical and medical treatment given is not to be nullified by poor care afterward.

⁹ This practice is in accordance with the report, "Hospital Care for the Needy," made by a joint committee of the American Hospital Association and the American Public Welfare Association in *Hospitals*, Vol. 13, No. 1 (January 1939), pp. 22-29.

In recognition of the importance of planning for aftercare service the Children's Bureau during 1938 made studies of discharge policies and procedures in several States.

Basic to a discharge plan are the medical recommendations for the child in respect to appliances, dressings, medication, activity, and diet. The plan should provide for further medical supervision, nursing supervision, and physical-therapy treatments, as necessary. The home situation in regard to income, housing, and the person who is to care for the child should be taken into consideration. Intangible factors such as the crippled child's reaction to physical handicap and the family's rejection or oversolicitude should be recognized as affecting the ultimate outcome. Educational opportunity at school, if possible, or at home should enter into the plan. The child's medical and social needs should form the basis for joint planning by the physician and the worker responsible for arranging to have plans carried out. Consultation with the parents by the surgeon and other professional personnel develops understanding and confidence in the parents in regard to the aftercare that is essential if satisfactory results are to be attained.

Some State agencies depend upon the medical-social worker in the hospital for planning aftercare service. In the better-developed State services the medical-social worker on the State staff is primarily responsible for planning at this point with the assistance of the hospital social worker, when available, the surgeon, and the local health and welfare agencies which can report on the family situation and resources. Some State agencies have developed plans whereby they are periodically informed of the child's condition and progress in the hospital so that they will be able to provide for the child when he is ready to leave. The home from which the patient comes and the resources of his community in terms of medical, nursing, and social services must be known to the State medical-social worker and to the hospital social worker so that they will be able to aid the physician in planning for the aftercare of the child.

There are many problems to be worked out in aftercare service, especially in rural areas. Recommendations regarding medical supervision may be difficult to carry out. Transportation represents a serious obstacle when the child must be taken many miles for re-examination. As families seek the advice of local physicians concerning their medical problems, it is necessary to keep the local physician informed of the child's progress and need for further care. The State clinics held periodically in different parts of the State are being used for follow-up medical examinations by specialists and for adjustment of braces. Local physicians are invited to be present so that they may be informed as to the recommendations of the orthopedic surgeon or the pediatrician.

The best place for a child to convalesce is his own home provided that home is satisfactory for his care. If the home is not equipped to provide for the needs of the crippled child during the convalescent period, first consideration should be given to augmenting the resources in the home to meet these needs. Such provision may be in the form of increased family income, additional household equipment, additional (personal) assistance in the home, or instruction of the parents so that they will fully understand how to care for the child. A home may be satisfactory from all points of view except that it is removed from a source of medical, nursing, or physical-therapy service.

If convalescence must be provided for outside the child's own home, the choice of convalescent home or foster home is based on the child's need. If the child continues to need an appreciable amount of regular medical and nursing service, the convalescent home or institution is indicated. It is being used as an extension of the hospital for periods of care that are relatively short. The foster home, which more nearly represents the natural family unit, is being used when and where possible for longer periods of care.

Placing a child in a foster home for a relatively extended period involves a responsibility that cannot be assumed lightly. The selection of a foster home demands skill, training, and experience. Not only must a prospective home qualify as a suitable foster home for children but also it must be proved to be a suitable home for the type of crippling condition from which the child is suffering and for the crippled child who is to be placed. The State crippled children's agencies, recognizing the seriousness of the responsibility, are finding it desirable to enlist the assistance of child-welfare agencies or child-welfare workers skilled in child placement to aid in finding suitable foster homes for crippled children. Of the 51 State agencies reporting for the fiscal year 1939, 30 reported the use of 81 convalescent homes for crippled children, and 526 foster homes were used in 36 States. Increasingly it is becoming possible to reduce the number of days of hospital care by the more extensive use of convalescent and foster homes.

In the hospital, during convalescence away from home, and after the child's return home, such schooling as it is possible to arrange for the crippled child is important in order that his educational handicap may be kept at a minimum. Where the school authorities have special funds for the education of crippled children, special teachers, special classes, and special schools can be provided. In many areas it is necessary for the State agency representatives to make what arrangements they can, with the aid of the school authorities and volunteer agencies, to provide teaching service or transportation to school.

Occupational-therapy activities in the hospital and the convalescent home are an important factor in aftercare services. Vocational training for the crippled boy or girl 16 years of age or over is now available in every State through the State vocational-rehabilitation service.

Quality of Service

The State crippled children's agencies recognize that maintaining a high quality of service is their most important administrative responsibility.

Standards for professional personnel to be employed on the State staff or to be engaged for the care of individual children have been established in most of the States, based upon requirements for certification by various national boards of medical specialties or other certifying bodies, such as the American Board of Orthopedic Surgery, the American Board of Pediatrics, and the American Registry of Physical Therapy Technicians, or on standards set by national organizations, such as the National Organization for Public Health Nursing and the American Association of Medical Social Workers. The review of State plans each year shows that increasingly these standards are being met in the selection of State staffs.

The qualifications of the surgeons providing services for crippled children under State programs have been maintained at a high level. Of the 535 orthopedic surgeons employed during the fiscal year 1939 by the State agencies, 68 percent were certified by the American Board of Orthopedic Surgery, a substantial increase over the number certified in the previous year. Forty-six percent of the specialists in plastic surgery employed by State agencies were certified by the American Board of Plastic Surgery or the American Board of Surgery. Of 189 nurses employed under the crippled children's program, 69 had completed an approved course in public-health nursing, 40 had preparation in orthopedic nursing, and 18 had completed an approved course in physiotherapy. Twenty-nine workers employed on State staffs had completed an approved course in medical-social work.

The strengthening of the State administrative staff is a natural corollary to the growing understanding that this is a program of medical service and that the professional services of the State staff—the orthopedic-nursing consultants, the medical-social workers, and the physical-therapy technicians—are as essential to the care of the crippled child as are surgical and hospital care, and must be considered service charges, not administrative charges.

In many States, particularly in those where difficulties have been encountered in finding resident personnel with the required qualifications, provisions have been made for further training of staff personnel. A considerable number of public-health nurses have received training in public-health nursing, in orthopedic nursing, and in physical

therapy. A number of medical-social workers and physical-therapy technicians have likewise been given supplementary training in their special fields to equip them for work with crippled children. During the fiscal year 1939, 73 persons received training in some field from crippled children's funds. Thirty-five received training in orthopedic nursing, 20 in public-health nursing, 14 in physiotherapy, and 4 in medical-social work.

Several universities and schools of nursing have arranged their nursing curricula to serve to best advantage the trainee who is taking a special course in public-health nursing or in orthopedic nursing in order that she may return to her State to serve as a consultant or to give direct service to crippled children. Schools of social work and centers for physical-therapy training have been interested in developing courses adapted to the needs of medical-social workers and physical-therapy technicians who are to work with crippled children.

The Social Security Act Amendments of 1939 included the requirement that the State plans for services for crippled children after January 1, 1940, should include provision for the establishment and maintenance of personnel standards on a merit basis. After consultation with the Federal agencies administering social-security programs and with State officials, the Children's Bureau issued recommended standards for the establishment and maintenance of a merit system of personnel administration, including qualifications for professional employees in the crippled children's program. These were issued for the guidance of the State crippled children's agencies.

The two orthopedic surgeons of recognized national standing employed as part-time consultants by the Children's Bureau have assisted the State crippled children's agencies in establishing active technical relationships with representatives of the medical profession within the States and in clarifying such relationships between the States, the Children's Bureau, and the various national orthopedic organizations. Their attendance at State and National medical meetings has contributed also toward increased understanding of the Federal-State services for crippled children by members of State and National orthopedic organizations and of the medical profession everywhere.

During trips into various States the orthopedic consultants and the regional medical consultants of the Children's Bureau, accompanied by surgeons participating in the State programs, have visited diagnostic clinics, hospitals, and convalescent homes. During such visits the discussions have resulted in suggestions and recommendations to the State agencies, hospitals, and participating surgeons. These cover such matters as: The location of future clinics and the inclusion in clinics of qualified technical personnel for nonoperative as well as operative orthopedic work; the desirability of medical review of

cases prior to authorization for treatment; the standardization of hospital admission procedures; the extension of the program to treatment of nonsurgical cases; the extension of pediatric and other consultation services; the improved selection of types of cases to be treated, with due regard to the possibility of physical restoration; the careful consideration of the necessary duration of treatment; the development of technical follow-up services, including adequate instruction on aftercare for local workers; the closer medical supervision of follow-up care to insure maximum benefit to the patient; and the maintenance of adequate technical records to cover each successive phase of care.

Local practicing physicians are urged to attend the crippled children's clinics to observe the examinations made by orthopedic surgeons and to discuss with the surgeons the cases referred to the clinic by them. Several State agencies have also conducted lecture courses for the instruction of local practicing physicians on the recognition of early signs and symptoms of crippling conditions and conditions that lead to crippling. Prompt treatment may prevent the development of the crippling condition or may lessen the severity of the injury.

Descriptions of standards being established by the State agencies for the approval of hospitals indicate that most of the States are using approval by the American College of Surgeons as a basis for the selection of a hospital. Registration by the American Medical Association is also considered in deciding whether a hospital should be used.

The State agencies, in establishing their hospital standards, are making use also of the special requirements for the care of crippled children included in the recommendations of the Children's Bureau Advisory Committee on Services for Crippled Children. The standards recommended for hospital care of crippled children included the employment on the hospital staff of the following:

An orthopedic surgeon certified by or eligible for certification by the American Board of Orthopedic Surgery.

At least one physical-therapy technician registered by or eligible for registration by the American Registry of Physical Therapy Technicians. All physical-therapy technicians employed should be responsible to the surgeon in charge.

At least one qualified nurse with experience in pediatric and orthopedic nursing.

At least one qualified medical-social worker.

The recommendations specify also that the physical-therapy equipment should include a room equipped with at least an exercise table and some form of radiant heat and that the hospital should provide

for the detection and isolation of children suffering from communicable disease. A further recommendation calls for the regular inspection for fire hazards of hospitals and convalescent homes used by State agencies for crippled children and for the compliance of such institutions with the minimum requirements of State law with respect to fire protection.

Of the 561 hospitals used for crippled children during the fiscal year 1939, 90 percent were approved by the American College of Surgeons. This is an improvement over the preceding year. On the recommendations of advisory committees, Federal and State, the State agencies started their programs by requiring approval by the American College of Surgeons as one of the basic hospital standards. From observation of the type of service provided by hospitals it is apparent that additional standards are needed to indicate whether a hospital is equipped to handle services for crippled children. Each year hospital facilities are improving, and more hospitals are meeting the established standards.

Through the steadily growing interest in the crippled children's program, hospital staffs have been increased and strengthened, and much needed equipment has been provided. Most of the State agencies have endeavored to find qualified hospitals well distributed throughout the State so that children may be cared for as near their homes as possible. Progress in that direction is necessarily slow because of the fact that orthopedists are generally located in the large urban centers.

Study has been given by both the State crippled children's agencies and the Children's Bureau to more definite standards for the approval of convalescent homes and foster homes. The need for increasing and improving convalescent homes remains one of the most important problems to be faced in the future development of the crippled children's program.

Whenever possible the foster homes selected for crippled children should be those conducted by graduate nurses. The State public-health nurse needs to maintain watchful supervision over the crippled child in the foster home to see that the foster mother understands the care needed by the child and to make sure that the child receives adequate medical supervision.

As it is desirable to return a convalescent child to his own home as soon as his condition permits, the quality of care that can be given by the parents and other members of the family is an important factor in planning care for a crippled child. In addition to arranging for augmenting the economic and physical resources of the home, if necessary the State crippled children's agency provides for educational service to the family to be given by the public-health nurse who ex-

plains the day-by-day care of the crippled child. It is becoming the practice for the State public-health-nursing consultant to transmit to the local public-health nurse the physician's or surgeon's instructions for the care of each crippled child after his return home, and for the local public-health nurse to visit the home periodically to watch the child's progress.

In many instances vocational guidance is given crippled children approaching 16 years of age, when they will be referred to the State vocational-rehabilitation service for training for some occupation. The attendance of a representative of the State vocational-rehabilitation service at diagnostic clinics conducted by the State crippled children's agency has tended to develop a very close cooperative working relationship in meeting the needs of the individual crippled child, with the result that many crippled children are now being better equipped for life, vocationally as well as physically and socially.

Crippled Children in the United States

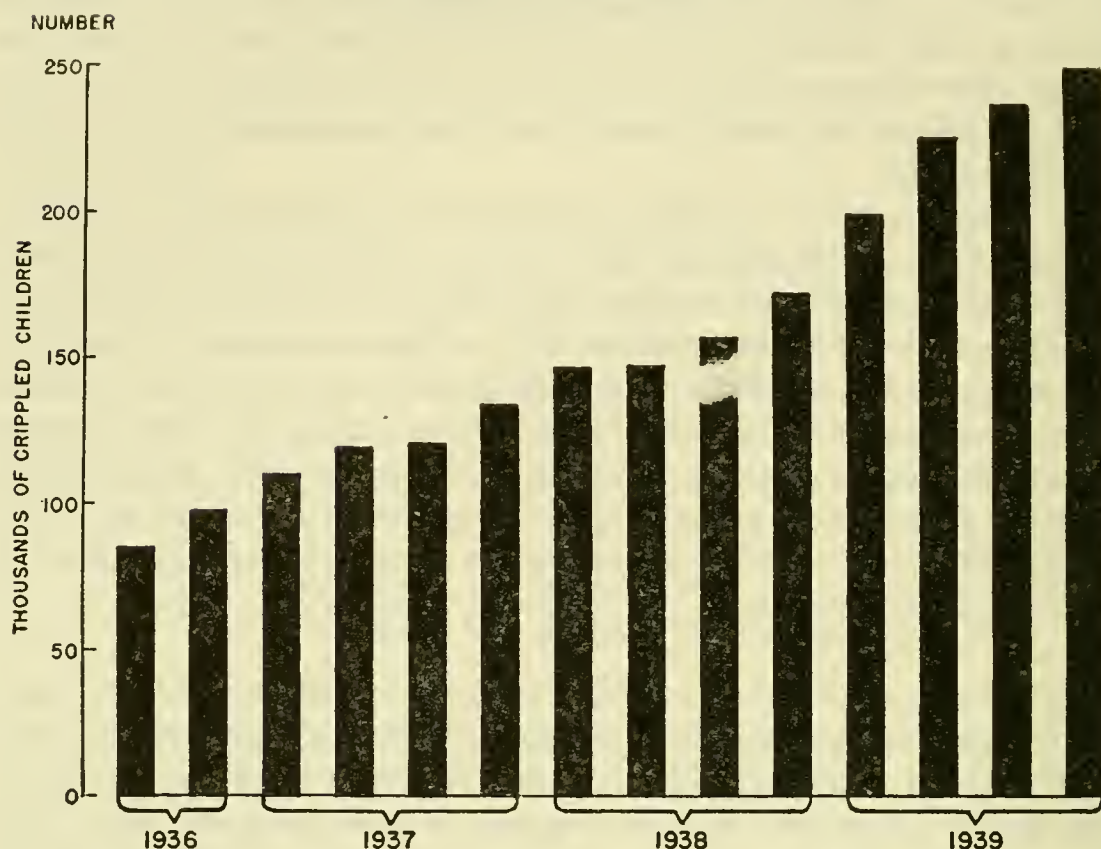
The State registers of crippled children on December 31, 1939, listed approximately 249,000 crippled children whose condition had been diagnosed by a physician. These registers, as shown by table 2 and chart 1, have been built up quarter by quarter since 1936, as the State crippled children's agencies, with the aid of Federal funds, developed their programs for locating crippled children and providing diagnostic service.

Table 2.—*Growth of State registers of crippled children, Sept. 30, 1936, to Dec. 31, 1939*

Quarter ended—	Number of crippled children registered	Number of States reporting
Sept. 30, 1936.....	85,000	34
Dec. 31, 1936.....	97,000	36
Mar. 31, 1937.....	109,000	37
June 30, 1937.....	119,000	39
Sept. 30, 1937.....	120,000	43
Dec. 31, 1937.....	133,000	44
Mar. 31, 1938.....	146,000	47
June 30, 1938.....	147,000	49
Sept. 30, 1938.....	156,000	50
Dec. 31, 1938.....	172,000	50
Mar. 31, 1939.....	199,000	50
June 30, 1939.....	225,000	51
Sept. 30, 1939.....	237,000	51
Dec. 31, 1939.....	249,000	51

The mounting registration figure is of interest in relation to estimates heretofore made of the numbers of crippled children in the United States. The White House Conference on Child Health and

Chart 1.—Growth of State Registers of Crippled Children, 1936–39
(Based on quarterly reports)



Protection, 1930, recognizing the limitations on the quantitative material then available, estimated that, depending on the type of crippling conditions covered, there were roughly 300,000 to 368,000 crippled children in the United States.¹⁰

More recent material (1935–36) made available through the National Health Survey has supported the use of an estimate of about 330,000 children with impairments of an orthopedic nature.¹¹

As the State registers are built up according to each State's legal or administrative definition of a crippled child, there is inevitably some variation in the types of crippling conditions included. The State registers so far include mainly children with orthopedic or plastic impairments, probably because the care provided by the State agencies is as yet chiefly for these conditions.

The number of crippled children registered in proportion to the population under 21 years of age ranged from 9.7 for Illinois down to

¹⁰ *The Handicapped Child*, pp. 133–136.

¹¹ *National Health Survey: Sickness and Medical Care Series, Bull. No. 4, The Prevalence and Causes of Orthopedic Impairments*. U. S. Public Health Service, Washington, 1938. This bulletin (p. 1) gives an estimate of 210,000 children under 15 years of age with orthopedic impairments; estimates for children 15 years of age and over have been made on the basis of rates published in table 2 and appendix table B.

1.1 for Louisiana ¹² (table 3). Although the growth of registration was marked during the years 1936-39, the low registration rates in many States indicate that the process of finding crippled children is still far from complete.

Table 3.—*Number of crippled children on State registers, Dec. 31, 1939, and number per 1,000 population under 21 years (1930 census), by State*

State	Number	Number per 1,000 population under 21 years	State	Number	Number per 1,000 population under 21 years
Total, 51 States	248, 627	5. 0	Washington	3, 249	5. 9
Illinois	26, 953	9. 7	Nevada	173	5. 7
North Carolina	15, 343	9. 4	West Virginia	4, 528	5. 5
Montana	2, 035	9. 3	Utah	1, 302	5. 4
Vermont	1, 252	9. 0	Colorado	2, 155	5. 2
Minnesota	9, 038	8. 8	Florida	3, 001	5. 0
Alaska	201	8. 7	Virginia	5, 330	4. 8
New Hampshire	1, 485	8. 7	Alabama	6, 062	4. 7
District of Columbia	1, 207	8. 3	South Carolina	4, 327	4. 7
Hawaii	1, 406	8. 0	Iowa	4, 472	4. 6
Delaware	660	7. 4	Indiana	5, 282	4. 3
Maine	2, 301	7. 4	California	7, 638	4. 2
Wyoming	686	7. 4	Texas	10, 174	3. 9
Rhode Island	1, 930	7. 2	Maryland	2, 219	3. 5
Idaho	1, 398	7. 1	Massachusetts	5, 473	3. 5
Kansas	5, 330	7. 1	South Dakota	1, 005	3. 3
Kentucky	8, 461	7. 1	Mississippi	2, 992	3. 1
Oklahoma	7, 841	7. 1	Tennessee	3, 525	2. 9
Wisconsin	7, 929	6. 8	Nebraska	1, 425	2. 5
New Mexico	1, 392	6. 7	Arkansas	1, 919	2. 2
New York	29, 849	6. 7	Ohio	5, 447	2. 2
Oregon	2, 243	6. 7	Connecticut	1, 228	2. 0
New Jersey	10, 049	6. 6	Georgia	2, 587	1. 8
Arizona	1, 172	6. 1	Missouri	2, 249	1. 7
North Dakota	1, 980	6. 1	Pennsylvania	6, 398	1. 6
Michigan	11, 304	5. 9	Louisiana	1, 022	1. 1

Based on the December 31, 1939, registration rates of the States showing the highest number of crippled children per 1,000 population under 21 years of age, the probable count for the United States will exceed 400,000 when the registration in each State is more complete. This estimate applies to the 1939 coverage, that is, mainly to children with orthopedic and plastic disabilities.

However, at the close of 1939, several States were about to undertake programs of care for children with rheumatic heart disease, which involves finding these children and listing them on State registers. As the States broaden their programs to cover more types of crippling conditions, the probable count of children with physical handicaps shown on State registers will undoubtedly exceed the estimates made of the numbers of children with orthopedic and plastic impairments.

¹² Although Louisiana has been providing care for crippled children for some time, the official program was adopted and the register established during 1939.

The Children on State Registers, 1938

A special study of the composition of State registers was made by the Children's Bureau at the end of June 1938, when 46 States,¹³ Alaska, Hawaii, and the District of Columbia reported a total of 146,506 crippled children on the State registers. The number of crippled children ranged from 156 in Alaska to 14,265 in North Carolina. Chart 2 (p. 29) shows the numbers registered per 1,000 population under 21 years of age as reported in the 1930 census. These rates ranged from 0.5 in Connecticut to 8.8 in North Carolina. The rate for the entire group of 46 States, Alaska, Hawaii, and the District of Columbia was 3.2.

The variations in the ratios of registered crippled children to child population reflect primarily differences in the completeness of the respective State registers, as explained below. A second important factor is the lack of uniformity in the definition of a "crippled child." Although true variations in the incidence of crippling doubtless exist, their influence is negligible in comparison with the other factors.

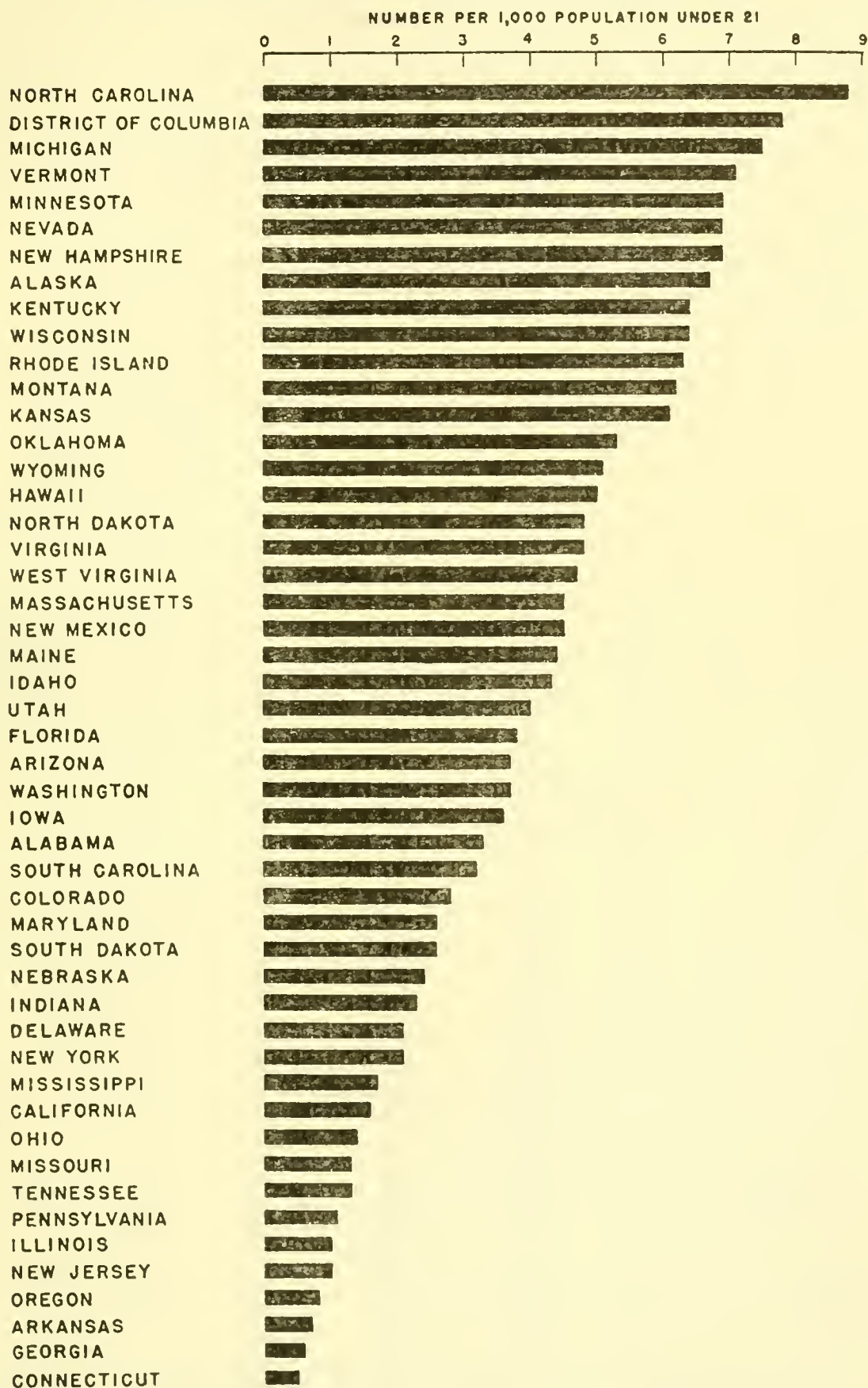
The completeness of the respective State registers may be influenced to some extent by the maturity of the State programs, a few of which have been in operation many years. Although 35 States had made appropriations for the care and treatment of crippled children prior to the passage of the Social Security Act, the amounts of money were very inadequate in some of these States, and only 12 had State-wide programs of the type made possible under the act. In a few States the delay in the registration in large metropolitan areas has resulted in comparatively low rates of crippled children registered.¹⁴

The term "crippled children" is variously defined in the several States. A review of State laws reveals differences extending from a definition limiting services to children with motor disabilities to a broad definition under which services may be made available to all physically handicapped children, except children whose chief disability is incurable blindness or deafness or who are mentally deficient. A few States specifically include conditions such as rheumatic heart disease and diabetes.

¹³ Texas and Louisiana did not report. Texas had not yet established a register, and Louisiana at that time was not participating in the crippled children's program under the Social Security Act.

¹⁴ Among the other factors affecting the completeness of the State registers were the amounts of State and local funds available for matching Federal funds, the effort directed by the official agency to the location of crippled children, the cooperation of other agencies and of private physicians in reporting crippled children, State policies with respect to ages of children accepted for care, and the strictness of the requirements for admission to the register. Although diagnosis by a licensed physician is now a prerequisite for registration in all States and although undiagnosed cases made up only 4 percent of the total on June 30, 1938, the percentage of undiagnosed cases in a few States was substantial.

Chart 2.—Number of Crippled Children on State Registers, June 30, 1938, per 1,000 Population Under 21 Years of Age (1930 Census), by State ¹



¹ Louisiana had no plan in operation and Texas had no official register as of this date.

Distribution by sex.

Of the total number of crippled children reported by all States, approximately 55 percent were boys and 45 percent were girls; in the 1930 census the percentages of boys and of girls under 21 in the population were about equal (50.4 and 49.6, respectively). Table 4 shows some variation in the percentages of boys and of girls on the registers of the several States, but without exception there were more boys than girls. The percentage of boys ranged from 50 in New York to 60 in Arkansas, Georgia, and Hawaii.

Table 4.—Sex of crippled children on State registers, by State, June 30, 1938

State ¹	Total number	Sex reported			Sex not reported
		Number	Percent distribution		
			Boys	Girls	Number
Total.....	146, 506	146, 115	55	45	391
Alabama ²	4, 346	4, 332	58	42	14
Alaska.....	156	154	56	44	2
Arizona.....	704	704	57	43	-----
Arkansas.....	655	655	60	40	-----
California.....	2, 920	2, 788	55	45	132
Colorado.....	1, 163	1, 163	54	46	-----
Connecticut.....	280	280	54	46	-----
Delaware.....	192	186	51	49	6
District of Columbia.....	1, 130	1, 128	54	46	2
Florida.....	2, 309	2, 309	55	45	-----
Georgia.....	860	860	60	40	-----
Hawaii.....	884	883	60	40	1
Idaho.....	862	862	55	45	-----
Illinois ³	2, 780	2, 765	56	44	15
Indiana.....	2, 781	2, 780	53	47	1
Iowa.....	3, 505	3, 505	54	46	-----
Kansas.....	4, 617	4, 605	55	45	12
Kentucky.....	7, 590	7, 590	55	45	-----
Maine.....	1, 350	1, 350	53	47	-----
Maryland.....	1, 637	1, 637	54	46	-----
Massachusetts.....	7, 041	7, 025	55	45	16
Michigan.....	14, 225	14, 225	53	47	-----
Minnesota.....	7, 083	7, 040	55	45	43
Mississippi.....	1, 693	1, 693	58	42	-----
Missouri.....	1, 816	1, 816	57	43	-----
Montana.....	1, 355	1, 340	53	47	15
Nebraska.....	1, 385	1, 385	58	42	-----
Nevada.....	209	209	56	44	-----
New Hampshire.....	1, 174	1, 167	56	44	7
New Jersey.....	1, 506	1, 506	52	48	-----
New Mexico.....	932	932	53	47	-----
New York.....	9, 346	9, 335	50	50	11
North Carolina.....	14, 265	14, 229	56	44	36
North Dakota.....	1, 557	1, 555	52	48	2
Ohio.....	3, 645	3, 645	54	46	-----
Oklahoma.....	5, 860	5, 807	58	42	53
Oregon.....	254	254	59	41	-----
Pennsylvania.....	4, 254	4, 254	52	48	-----
Rhode Island.....	1, 668	1, 668	53	47	-----
South Carolina.....	2, 974	2, 969	56	44	5
South Dakota.....	791	791	53	47	-----
Tennessee.....	1, 550	1, 546	57	43	4
Utah.....	985	985	58	42	-----
Vermont.....	994	994	54	46	-----
Virginia.....	5, 385	5, 385	54	46	-----
Washington.....	2, 056	2, 056	53	47	-----
West Virginia.....	3, 878	3, 867	55	45	11
Wisconsin.....	7, 435	7, 435	53	47	-----
Wyoming.....	469	466	55	45	-----

¹ Louisiana and Texas did not report. Texas had not yet established a register, and Louisiana was not participating in the crippled children's program under the Social Security Act.

² Included 397 children for whom eligibility had not been determined as of June 30, 1938.

³ As of Sept. 30, 1938.

Distribution by age.

The number and percentage of registered crippled children in each of the various age groups are shown in table 5, together with the percentage distribution of children in the same age groups in the general population. These figures indicate that only 17 percent of the crip-

Table 5.—*Age distribution of crippled children on State registers June 30, 1938, and of general population under 21 years of age, 1930 census*

Age group	Children		Percent of general population under 21
	Number	Percent	
Total.....	146, 506		
Age reported.....	143, 533	100	100
Under 1 year.....	3, 308	2	4
1 year, under 5.....	20, 887	15	19
5 years, under 10.....	33, 531	23	25
10 years, under 15.....	42, 827	30	24
15 years, under 20.....	36, 613	26	23
20 years, under 21.....	6, 367	4	5
Age not reported.....	2, 973		

pled children registered were under 5 years of age, whereas fully 30 percent fell in the age group 10 years but under 15. The following tabulation of cumulative percentages also reveals differences in the distribution by age groups of registered crippled children and of children in the general population:

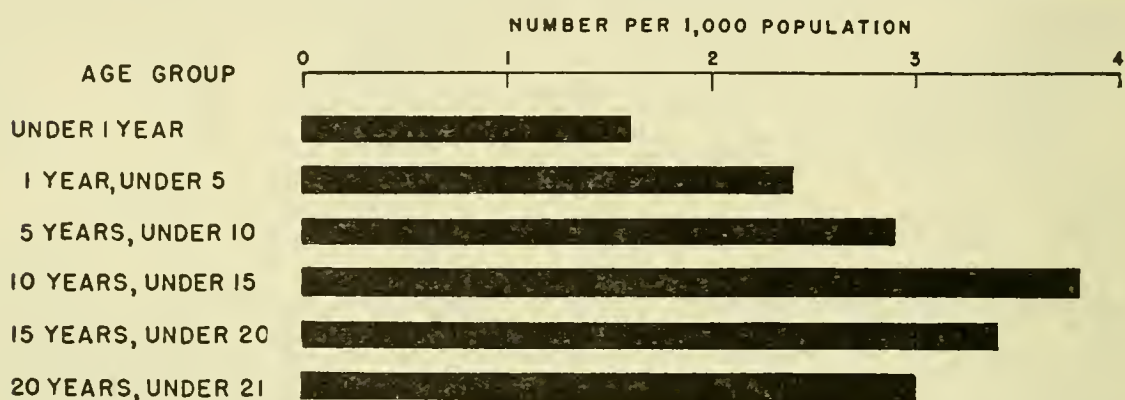
Age group	Cumulative percent distribution	
	Crippled children on State registers June 30, 1938	General population under 21 (1930 census)
Under 1 year.....	2	4
Under 5 years.....	17	23
Under 10 years.....	40	48
Under 15 years.....	70	72
Under 20 years.....	96	95
Under 21 years.....	100	100

Comparison of the age distribution of registered crippled children with that of the entire population under 21 in 1930 shows that infants and younger children were not yet proportionately represented on the registers of crippled children. Children under 10 years of age made up 48 percent of the total child population, but only 40 percent of the children registered as crippled.

The difference between the age distribution of registered crippled children and that of children in the general population is illustrated in chart 3. Crippled children on the register included 1.6 children under 1 year of age for every 1,000 children of the same age in the general population. The corresponding rate for children 1 year but

under 5 is 2.4 and for children 5 years but under 10, 2.9; the rates for crippled children 10 years but under 15, 15 years but under 20, and 20 years but under 21 were 3.8, 3.4, and 3.0, respectively. Although the low rates for very young children may reflect to some extent the smaller number of annual births since 1930 and consequent smaller number of children in the lower age groups, the extent of the variations indicates that differences in the incidence of crippling may have been operative. An unintentional selective emphasis in locating crippled children or in compiling the registers may also have been operating.

Chart 3.—Number of Crippled Children in Specified Age Groups on State Registers, June 30, 1938, per 1,000 Population in Same Age Groups (1930 Census)



Thus, since many State agencies had not yet perfected their procedures for obtaining information from birth certificates, the number of congenital deformities and birth injuries may have been understated in the younger age groups.

When the figures for crippled children on the various State registers are analyzed, wide variations are found in the proportions classified in the several age groups (table 6). The proportion of the total number of children registered who were under 1 year of age varied from less than 0.5 percent in Idaho, Massachusetts, and Rhode Island to 14 percent in New Jersey and Ohio; the proportion in the age group 1 year but under 5, from 5 percent in Massachusetts and Nevada to 28 percent in Kentucky; in the age group 5 years but under 10, from 15 percent in Massachusetts to 43 percent in Ohio; in the age group 10 years but under 15, from 13 percent in Ohio to 49 percent in Virginia; in the age group 15 years but under 20, from 8 percent in Ohio to 40 percent in Washington; among children 20 but under 21 years of age, from none in Virginia to 12 percent in North Carolina. The reasons for the variations are manifold and in many cases reflect restrictions operative under State laws, local practices, or activities of various organizations. The unusually high proportion of infants on the registers in New Jersey and in Ohio (both 14 percent) apparently resulted from the fact that crippling conditions

diagnosed at birth were reported to the State agency on birth certificates as a matter of routine. The unusually low proportions of children 15 years of age and over in Kentucky (10 percent) and in Ohio (8 percent) resulted apparently, at least in part, from the fact

Table 6.—*Age of crippled children on State registers, by State, June 30, 1938*

State ¹	Total number	Age reported							Age not reported (number)
		Number	Percent distribution						
			Under 1 year	1 year, under 5	5 years, under 10	10 years, under 15	15 years, under 20	20 years, under 21	
Total	146, 506	143, 533	2	15	23	30	26	4	2, 973
Alabama ²	4, 346	4, 194	2	17	28	28	22	3	152
Alaska	156	143	1	10	33	31	20	5	13
Arizona	704	702	1	13	28	30	25	3	2
Arkansas	655	590	4	27	24	28	14	3	65
California	2, 920	2, 655	1	12	21	32	30	4	265
Colorado	1, 163	1, 163	1	12	22	30	28	7	-----
Connecticut	280	280	5	19	29	25	20	2	-----
Delaware	192	186	4	18	32	29	15	2	6
District of Columbia	-----	-----	-----	-----	-----	-----	-----	-----	-----
Florida	1, 130	1, 106	1	13	22	39	24	1	24
Georgia	2, 309	2, 303	2	17	24	32	24	1	6
Hawaii	860	860	1	12	25	34	26	2	-----
Hawaii	884	877	4	17	22	30	23	4	7
Idaho	862	860	(³)	16	21	31	29	3	2
Illinois ⁴	2, 780	2, 668	1	17	20	29	28	5	112
Indiana	2, 781	2, 654	3	19	27	31	19	1	127
Iowa	3, 505	3, 505	9	19	22	27	17	6	-----
Kansas	4, 617	4, 570	1	14	22	28	30	5	47
Kentucky	7, 590	7, 540	6	28	30	26	10	(³)	50
Maine	1, 350	1, 327	2	21	28	29	17	3	23
Maryland	1, 637	1, 637	1	19	27	32	19	2	-----
Massachusetts	7, 041	6, 768	(³)	5	15	34	38	8	273
Michigan	14, 225	14, 159	1	14	22	30	30	3	66
Minnesota	7, 083	7, 054	1	10	21	29	33	6	29
Mississippi	1, 693	1, 693	6	19	27	27	18	3	-----
Missouri	1, 816	1, 816	4	19	26	27	22	2	-----
Montana	1, 355	1, 263	2	12	23	28	30	5	92
Nebraska	1, 385	1, 375	2	17	32	33	15	1	10
Nevada	209	208	4	5	32	36	19	4	1
New Hampshire	1, 174	1, 117	1	15	28	31	22	3	57
New Jersey	1, 506	1, 506	14	20	21	23	20	2	-----
New Mexico	932	892	1	15	23	36	19	6	40
New York	9, 346	9, 164	1	13	24	29	30	3	182
North Carolina	14, 265	13, 843	1	10	19	29	29	12	422
North Dakota	1, 557	1, 515	1	17	22	32	25	3	42
Ohio	3, 645	3, 645	14	22	43	13	8	(³)	-----
Oklahoma	5, 860	5, 848	1	15	28	24	27	5	12
Oregon	254	253	2	11	22	29	34	2	1
Pennsylvania	4, 254	4, 212	1	17	26	33	23	(³)	42
Rhode Island	1, 668	1, 634	(³)	10	25	32	27	6	34
South Carolina	2, 974	2, 522	3	16	22	30	23	6	452
South Dakota	791	789	1	17	22	26	27	7	2
Tennessee	1, 550	1, 526	1	15	27	33	22	2	24
Utah	985	985	3	15	22	32	27	1	-----
Vermont	994	879	1	17	26	29	23	4	115
Virginia	5, 385	5, 385	4	15	17	49	15	-----	-----
Washington	2, 056	2, 048	1	10	16	26	40	7	8
West Virginia	3, 878	3, 715	1	13	25	32	25	4	163
Wisconsin	7, 435	7, 435	3	13	22	28	28	6	-----
Wyoming	469	464	1	12	23	27	33	4	5

¹ Louisiana and Texas did not report. Texas had not yet established a register, and Louisiana was not participating in the crippled children's program under the Social Security Act.

² Included 397 children for whom eligibility had not been determined as of June 30, 1938.

³ Less than 0.5 of 1 percent.

⁴ As of Sept. 30, 1938.

that 17 is the age limit above which children may not be accepted for care by these State agencies. Although the registers are intended to include all crippled children under 21 years of age regardless of the age limit that may be observed by the State in providing treatment, it is evident that such limits have had an effect on the composition of the registers.

Distribution by race.

The data presented in table 7 indicate that whereas 88 percent of the total population under 21 years of age was classified in the 1930 census as white, 10 percent as Negro, and 2 percent as "other," ap-

Table 7.—Race distribution of crippled children on State registers June 30, 1938, and of general population under 21 years of age, 1930 census

Race	Children		Percent of general population under 21
	Number	Percent	
Total.....	146, 506		
Race reported.....	141, 205	100	100
White.....	128, 648	91	88
Negro.....	10, 272	7	10
Other.....	2, 285	2	2
Race not reported.....	5, 301		

proximately 91 percent of the crippled children on State registers in June 1938 were white, 7 percent were Negro, and 2 percent were classified as "other." This comparison indicates that approximately one-third fewer Negroes were included on the registers of crippled children than would be included if Negroes were proportionately represented on the registers. Table 8 shows the racial distribution of registered crippled children by States.

In chart 4 is shown the number of white and Negro crippled children registered per 1,000 population of these races under 21 years of age for all States in which more than 5 percent of the population under 21 years of age in 1930 was Negro. In a number of these States the rate for crippled Negro children on the registers was less than two-thirds of the rate for crippled white children. On the other hand the rate for crippled Negro children on the registers in certain other States exceeded the rate for crippled white children.

Table 8.—Race of crippled children on State registers, by State,
June 30, 1938

State ¹	Total number	Race reported				Race not reported (number)
		Number	Percent distribution			
			White	Negro	Other	
Total	146, 506	141, 205	91	7	2	5, 301
Alabama ²	4, 346	4, 229	81	19	(³)	117
Alaska	156	156	15	-----	85	-----
Arizona	704	704	58	1	41	-----
Arkansas	655	655	88	12	-----	-----
California	2, 920	2, 137	86	1	13	783
Colorado	1, 163	1, 163	99	1	(³)	-----
Connecticut	280	280	99	1	-----	-----
Delaware	192	186	62	38	-----	6
District of Columbia	1, 130	1, 116	63	37	(³)	14
Florida	2, 309	2, 309	83	17	-----	-----
Georgia	860	860	85	15	-----	-----
Hawaii	884	884	21	-----	79	-----
Idaho	862	862	100	(³)	(³)	-----
Illinois ⁴	2, 780	2, 780	91	2	7	-----
Indiana	2, 781	2, 604	96	4	-----	177
Iowa	3, 505	3, 505	100	(³)	(³)	-----
Kansas	4, 617	4, 581	96	3	1	36
Kentucky	7, 590	7, 590	96	4	-----	-----
Maine	1, 350	1, 350	100	-----	-----	-----
Maryland	1, 637	1, 637	86	14	-----	-----
Massachusetts	7, 041	6, 971	99	1	(³)	70
Michigan	14, 225	12, 128	97	3	(³)	2, 097
Minnesota	7, 083	6, 445	98	(³)	2	638
Mississippi	1, 693	1, 693	62	38	(³)	-----
Missouri	1, 816	1, 816	96	4	-----	-----
Montana	1, 355	1, 355	96	(³)	4	-----
Nebraska	1, 385	1, 318	99	1	(³)	67
Nevada	209	208	95	(³)	5	1
New Hampshire	1, 174	1, 174	100	(³)	-----	-----
New Jersey	1, 506	1, 506	94	6	-----	-----
New Mexico	932	932	100	(³)	(³)	-----
New York	9, 346	9, 223	99	1	(³)	123
North Carolina	14, 265	13, 975	83	16	1	290
North Dakota	1, 557	1, 557	98	(³)	2	-----
Ohio	3, 645	3, 139	95	5	-----	506
Oklahoma	5, 860	5, 848	93	4	3	12
Oregon	254	254	98	(³)	2	-----
Pennsylvania	4, 254	4, 254	99	1	-----	-----
Rhode Island	1, 668	1, 668	99	1	-----	-----
South Carolina	2, 974	2, 635	58	42	(³)	339
South Dakota	791	791	100	-----	-----	-----
Tennessee	1, 550	1, 546	94	6	-----	4
Utah	985	985	99	-----	1	-----
Vermont	994	994	100	(³)	-----	-----
Virginia	5, 385	5, 385	63	37	-----	-----
Washington	2, 056	2, 056	98	(³)	2	-----
West Virginia	3, 878	3, 857	94	6	(³)	21
Wisconsin	7, 435	7, 435	100	(³)	(³)	-----
Wyoming	469	469	98	-----	2	-----

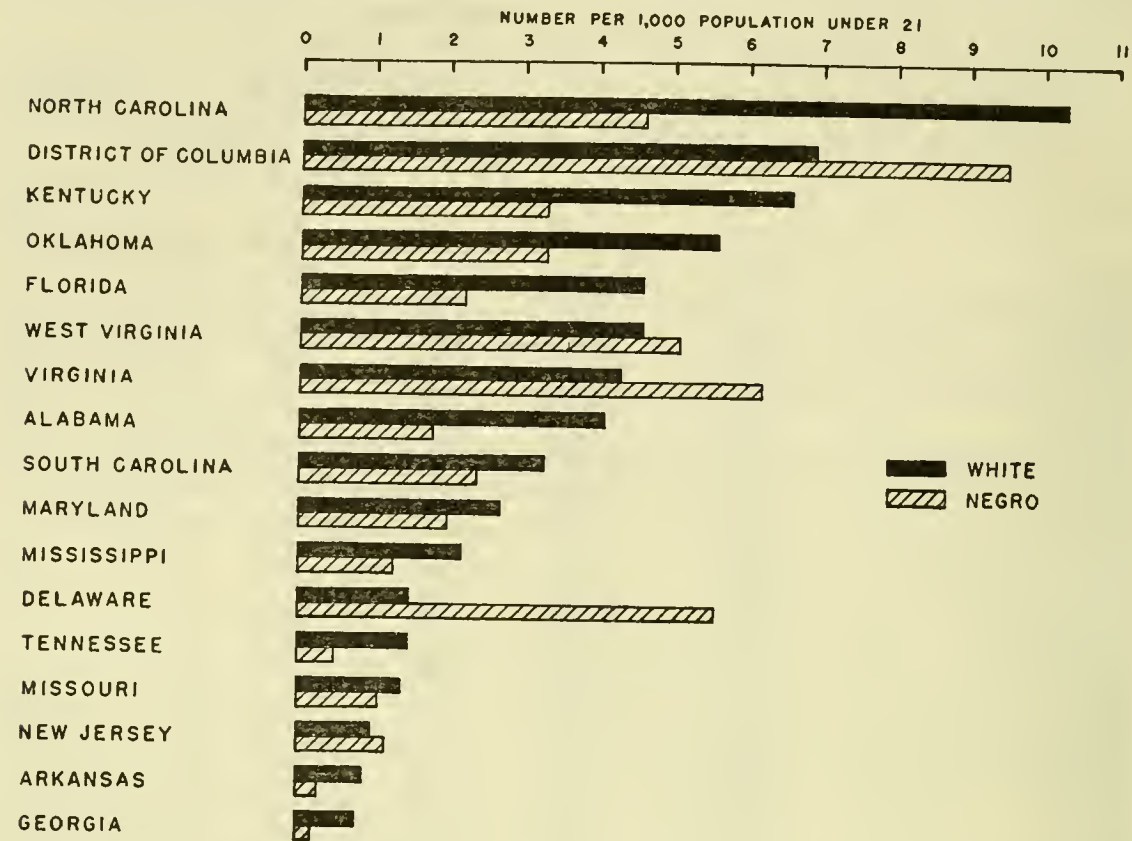
¹ Louisiana and Texas did not report. Texas had not yet established a register, and Louisiana was not participating in the crippled children's program under the Social Security Act.

² Included 397 children for whom eligibility had not been determined as of June 30, 1938.

³ Less than 0.5 of 1 percent.

⁴ As of Sept. 30, 1938.

Chart 4.—Number of White and Negro Crippled Children on State Registers, June 30, 1938, per 1,000 Population of These Races Under 21 Years of Age (1930 Census) for Selected States ¹



¹ Includes all States in which more than 5 percent of the population under 21 years of age (1930) was Negro.

Distribution by principal types of diagnosis.

The inclusion on the register of an overwhelming preponderance of children with orthopedic or plastic conditions is evident from table 9.

Table 9.—Number of crippled children on State registers, by type of diagnosis, June 30, 1938

Diagnosis	Children	
	Number	Percent
Total.....	146,506	-----
Diagnosis reported.....	140,007	100
Orthopedic or plastic conditions.....	136,081	97
Other crippling conditions.....	3,926	3
Diagnosis not reported.....	6,499	-----

Approximately 97 percent of all children on State registers, for whom there was a diagnosis by a licensed physician, had orthopedic or plastic impairments resulting from congenital malformations such as cleft palate, harelip, and clubfoot; from birth injuries; from cerebral palsy; from infectious diseases such as poliomyelitis, osteomyelitis, tuber-

culosis of bone or joint; from accidents, and so forth. Three percent had other types of crippling conditions.

The figures in table 10 show the variations in the general types of crippling conditions for which children were included on the various State registers. Eleven States included orthopedic or plastic conditions only, whereas in five States more than 10 percent of the children registered were classified as having crippling conditions not of an orthopedic or plastic nature.

Table 10.—*Number of crippled children on State registers, by type of diagnosis and by State, June 30, 1938*

State ¹	Total number	Diagnosis reported			Diagnosis not reported (number)
		Number	Percent distribution		
			Orthopedic or plastic conditions	Other crippling conditions	
Total.....	146, 506	140, 007	97	3	6, 499
Alabama ²	4, 346	4, 243	99	1	103
Alaska.....	156	122	87	13	34
Arizona.....	704	704	100	(³)	-----
Arkansas.....	655	595	97	3	60
California.....	2, 920	2, 920	80	20	-----
Colorado.....	1, 163	1, 163	100	-----	-----
Connecticut.....	280	277	97	3	3
Delaware.....	192	163	100	-----	29
District of Columbia.....	1, 130	1, 130	63	37	-----
Florida.....	2, 309	2, 301	98	2	8
Georgia.....	860	806	97	3	-----
Hawaii.....	884	884	94	6	-----
Idaho.....	862	842	98	2	20
Illinois ⁴	2, 780	2, 512	100	-----	268
Indiana.....	2, 781	2, 781	100	-----	-----
Iowa.....	3, 505	3, 505	99	1	-----
Kansas.....	4, 617	4, 617	99	1	-----
Kentucky.....	7, 590	7, 590	100	-----	-----
Maine.....	1, 350	1, 338	97	3	12
Maryland.....	1, 637	1, 637	99	1	-----
Massachusetts.....	7, 041	4, 944	99	1	2, 097
Michigan.....	14, 225	12, 723	99	1	1, 502
Minnesota.....	7, 083	6, 442	92	8	641
Mississippi.....	1, 693	1, 603	93	7	90
Missouri.....	1, 816	1, 816	95	5	-----
Montana.....	1, 355	1, 355	99	1	-----
Nebraska.....	1, 385	1, 263	94	6	122
Nevada.....	209	172	83	17	37
New Hampshire.....	1, 174	1, 159	96	4	15
New Jersey.....	1, 506	1, 506	100	-----	-----
New Mexico.....	932	932	91	9	-----
New York.....	9, 346	9, 219	100	(³)	127
North Carolina.....	14, 265	14, 080	96	4	185
North Dakota.....	1, 557	1, 557	93	7	-----
Ohio.....	3, 645	3, 612	95	5	33
Oklahoma.....	5, 860	5, 860	100	-----	-----
Oregon.....	254	254	100	-----	-----
Pennsylvania.....	4, 254	4, 195	95	5	59
Rhode Island.....	1, 668	1, 420	94	6	248
South Carolina.....	2, 974	2, 647	97	3	327
South Dakota.....	791	791	89	11	-----
Tennessee.....	1, 550	1, 550	100	-----	-----
Utah.....	985	864	96	4	121
Vermont.....	994	994	100	-----	-----
Virginia.....	5, 385	5, 385	100	-----	-----
Washington.....	2, 056	2, 056	99	1	-----
West Virginia.....	3, 878	3, 796	98	2	82
Wisconsin.....	7, 435	7, 164	99	1	271
Wyoming.....	469	464	100	(³)	5

¹ Louisiana and Texas did not report. Texas had not yet established a register, and Louisiana was not participating in the crippled children's program under the Social Security Act.

² Included 397 children for whom eligibility had not been determined as of June 30, 1938.

³ Less than 0.5 of 1 percent.

⁴ As of Sept. 30, 1938.

Classification of Crippling Conditions by Diagnosis, 1939

The State crippled children's agencies were asked to report the diagnosis for all children on the State registers on December 31, 1939. Table 11 and chart 5 show the diagnoses according to reports received from 42 States, the District of Columbia, Alaska, and Hawaii. All diagnoses were made by licensed physicians.

The study showed that 10 types of crippling conditions accounted for 62 percent of the crippled children on the State registers. Poliomyelitis, cerebral palsy, clubfoot, and osteomyelitis were given as the diagnosis for more than two-fifths of the children (43 percent). The other 6 of the 10 principal diagnoses—harelip or cleft palate, tuberculosis of the bones and joints, scoliosis, rickets, birth paralysis, and burns—were recorded for approximately one-fifth of the children (19 percent). All other diagnoses accounted for the remaining two-fifths.

The classification "All other definite diagnoses," which accounted for 36 percent of the children, covers many diverse conditions, such as congenital absence of parts, congenital dislocations of the hip, muscular dystrophy, spina bifida, arthritis, neoplasms, un-united fractures, and flatfoot, as well as cardiac disease, congenital cataract, diabetes, and other nonorthopedic conditions. Individually each of these conditions occurred infrequently, but combined they made up an important proportion of the registration.

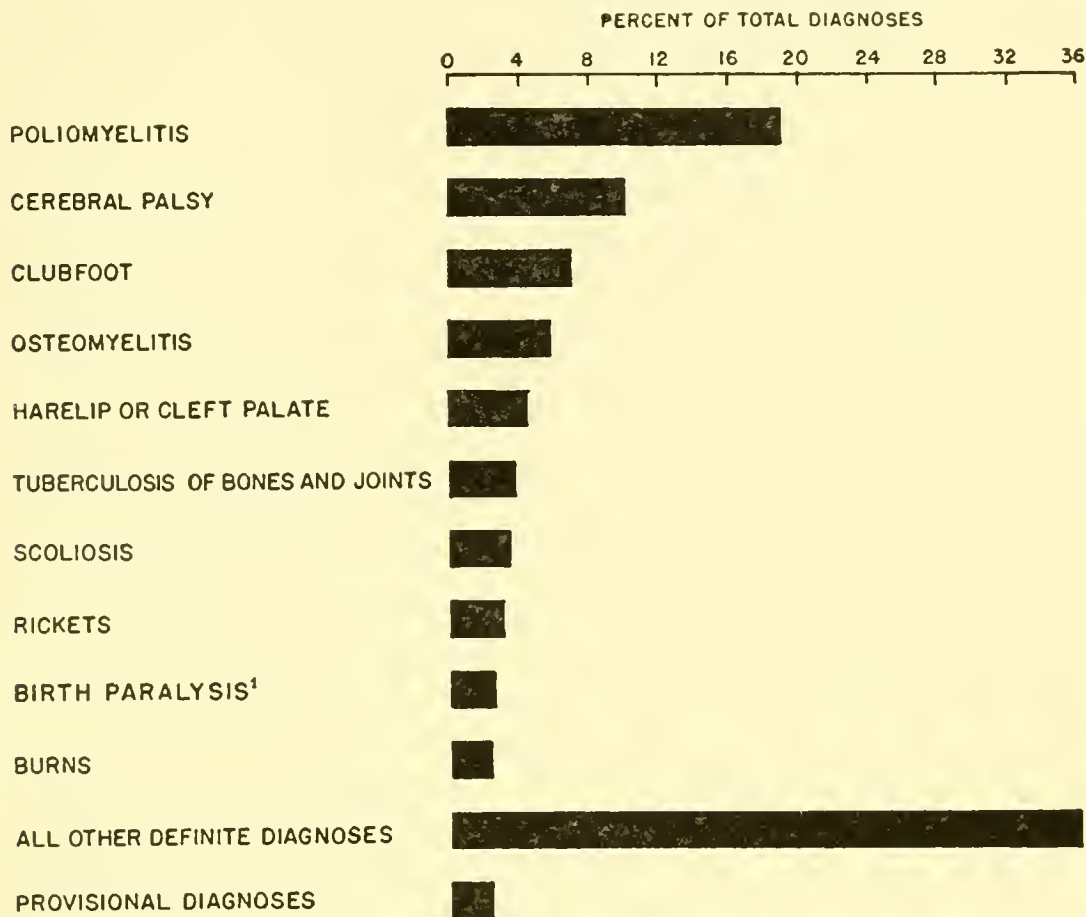
Table 11.—*Number in specific diagnostic classifications, percent distribution, and number per 10,000 population under 21 years; crippled children on State registers, Dec. 31, 1939*

Diagnostic classification ¹	Crippled children		
	Number	Percent	Number per 10,000 population under 21 years (1930 census)
Total, 45 States.....	188, 579	100. 0	50. 0
1. Poliomyelitis.....	36, 271	19. 2	9. 6
2. Cerebral palsy.....	19, 172	10. 2	5. 1
3. Paralysis due to birth injury (exclusive of cerebral palsy)....	4, 532	2. 4	1. 2
4. Clubfoot.....	13, 784	7. 3	3. 7
5. Harelip or cleft palate.....	8, 232	4. 4	2. 2
6. Tuberculosis of bones and joints.....	7, 196	3. 8	1. 9
7. Osteomyelitis.....	11, 112	5. 9	2. 9
8. Scoliosis.....	6, 746	3. 6	1. 8
9. Rickets.....	5, 607	3. 0	1. 5
10. Burns.....	4, 161	2. 2	1. 1
11. All other definite diagnoses.....	67, 410	35. 7	17. 9
12. Provisional diagnoses ²	4, 356	2. 3	1. 1

¹ The numbers recorded represent children, not conditions; therefore only one diagnosis is recorded here for each child, and that is the primary one.

² Item 12 is reserved for that relatively small group of cases about which there is: (1) Uncertainty between diagnoses; (2) only an indefinite diagnosis, such as "question of—" or "suspicious of—", available at the time of this report; (3) grave doubt about the correctness of the diagnosis. This item is used only when it is impossible to make a definite diagnosis.

Chart 5.—Percentage Distribution of Crippled Children, by Diagnosis, Dec. 31, 1939



¹ Paralysis due to birth injury (exclusive of cerebral palsy).

Services Rendered Crippled Children

The State crippled children's agencies began making reports to the Children's Bureau on their activities on July 1, 1936, but the reports for the first 6 months were fragmentary. For the calendar year 1937 reports were received from all the States, except Louisiana and Oregon, and from Alaska, Hawaii, and the District of Columbia. Oregon began reporting in 1938 and Louisiana figures are included for the year 1939.

The apparent increases in the figures for 1939 as compared with 1938 shown in table 12 may be due to an increase in the number of States reporting, to a real increase in the amount of service provided, to a difference in the number of agencies and institutions included in the reports, to a difference in the accuracy or completeness of reporting, to statistical errors due to variations in interpretations of terms, or to other factors. Several of these factors related to the initiation of a new reporting system will grow less significant as each quarterly report is prepared. After due allowance is made for various fortuitous factors which may have influenced the increase, the figures undoubtedly can be accepted as showing a real increase in the amount of service rendered.

From the standpoint of the numbers of crippled children served, probably the most significant figures are the number of admissions of crippled children to clinic service for diagnosis or treatment, 88,581 in 1939, and the number of children under care in hospitals, 41,692 in 1939. The children admitted to other services received clinic service or hospital care as well and, therefore, are counted in these figures.

The numbers of children under care at the close of 1939 are significant in showing the number of crippled children under care outside their own homes at a given time: 3,492 children in hospitals; 1,438 in convalescent homes; and 591 in foster homes. The increases in the last two figures as compared with 1938 undoubtedly reveal a substantial advance in the provision of these types of care by the State agencies. The State reports, at the present time, do not show the number of children undergoing medical treatment in their own homes.

Table 12.—*Crippled children on State registers and services for crippled children, calendar years 1938 and 1939*

[Reported by official State agencies administering State plans under the Social Security Act, title V, part 2]

Item	Number reported ¹	
	1939	1938
Crippled children on State registers at end of year	248, 627	171, 564
Services for crippled children:		
Clinic service (diagnostic or treatment):		
Admissions	88, 581	79, 590
Visits	193, 322	181, 206
Hospital care:		
Children under care during year ²	41, 692	43, 097
Children under care at end of year	3, 492	3, 330
Days' care provided during year	1, 374, 773	1, 398, 086
Convalescent-home care:		
Children under care during year ²	6, 537	5, 938
Children under care at end of year	1, 438	1, 028
Days' care provided during year	410, 621	371, 840
Foster-home care:		
Children under care during year ²	2, 645	1, 890
Children under care at end of year	591	302
Days' care provided during year	126, 773	86, 858
Public-health-nursing service:		
Admissions	54, 915	40, 847
Field and office visits	206, 717	177, 292
Physical-therapy service:		
Admissions	10, 327	9, 373
Field and office visits	172, 328	78, 952
Medical-social service: Admissions	16, 272	12, 601
Vocational rehabilitation: Children referred for vocational services ..	3, 659	4, 640

¹ Reports for 1938 were received from 47 States, Alaska, Hawaii, and the District of Columbia; Louisiana was not participating. For 1939 reports were received from all the States, Alaska, Hawaii, and the District of Columbia.

² Total number of children under care at beginning of year and those admitted or readmitted to care during the year.

Note.—The figures in this table are known to be somewhat incomplete; figures on admissions and visits are fairly dependable as an indication of the amount of service provided, but, on account of inconsistencies in the methods used by the States in reporting, these figures should not be used for computing average visits per admission.

The State reports are also significant in revealing the volume of public-health-nursing, social, and physical-therapy service rendered as services auxiliary to medical diagnosis and treatment. The increase in these services in 1939 as compared with earlier years to a large extent reflects the development of the aftercare program, one of the major accomplishments of the State crippled children's agencies since the crippled children's program under the Social Security Act was started.

Limitations of the Crippled Children's Program

The low registration of crippled children in some of the States will be overcome in part as the continuance of the program makes it possible for the State agencies to attain a more complete coverage of the States in finding crippled children and in providing for diagnosis of the crippling conditions affecting them. Too, the total number to be registered will increase if the coverage of the crippled children's program is extended, as is recommended in the national health program, to provide services for physically handicapped children other than those suffering from orthopedic and plastic conditions.

The development of the crippled children's program in some States and Territories was retarded by the inability of these jurisdictions to match Federal grants dollar for dollar with State or local public funds or funds made available for public use, as was required during the first 3½ years of the program. (Chart 6.) The inclusion in the Social Security Act Amendments of 1939 of a provision authorizing the appropriation of an additional \$1,000,000 each year for grants to the States, based on the financial need of each State for assistance in carrying out its State plan, will enable the Secretary of Labor, in allotting funds to the States, to take into consideration the ability of the States to finance the State share of the program. Allotments from this additional fund, for which matching by State and local funds is not required, will make more nearly equal in all States the opportunity afforded crippled children to benefit from the Federal-State program.

In a considerable number of the States the rendering of service to children whose condition has been diagnosed has been retarded either because funds to pay for surgical and hospital care have been insufficient or because a sufficient number of hospital beds have not been available. On May 15, 1939, 34 of 51 State crippled children's agencies reported that nearly 13,000 crippled children were awaiting hospitalization because of lack of funds, 15 reported that more than 1,200 crippled children were waiting because of lack of hospital beds, and 7 reported that more than 400 were waiting for other reasons.

Chart 6.—Percentages of Annual Federal Allotments of Funds for Services for Crippled Children, Matched by States in the Fiscal Years 1937 and 1939, Social Security Act, Section 512 (a)



Bars extending to 100 percent on scale indicate that States represented supplied matching funds in the amount of 100 percent or more of annual Federal allotments.

The States have gradually raised the maximum age for assistance to crippled children in their eligibility requirements. By June 30, 1939, crippled children up to 21 years of age were accepted for care by the State agencies of 45 States. Of these, 1 State had an age limit of 18 years and 3 States of 16 years for eligibility for care from State funds, but Federal funds were being used in these States to extend service to crippled children up to 21 years of age. One of the 45 States still gave preference to children under 16 years of age. For

the remaining 6 States with plans in operation, the age limit was 18 years for 3 States, 17 years for 1 State, 16 years for 1 State, and 15 years for 1 State.

A majority of States require legal residence in the State as a prerequisite to the giving of care from State funds. Some State agencies have made reciprocal agreements with other State agencies whereby financial responsibility for the care of children is accepted until such time as legal residence is acquired.

There are in this country large unmet needs of handicapped children with many types of crippling other than orthopedic and plastic impairments. For example, it is estimated that there are approximately 400,000 children suffering from rheumatic heart disease; approximately 60,000 children with severe visual defects; and several million school children with visual defects that require correction with glasses. More than 1½ million children have defective hearing, and more than two-thirds of all school children have dental defects.

In the report on a national health program made by the Technical Committee on Medical Care, submitted to the President in 1938 by the Interdepartmental Committee To Coordinate Health and Welfare Activities, the Technical Committee recognized the progress made under the crippled children's provisions of the Social Security Act in making available orthopedic and plastic surgical service, hospitalization, and aftercare. The Committee called attention to the need for further provision for children crippled or handicapped from heart disease, diabetes, congenital syphilis, and other conditions that require prolonged care to insure recovery or restoration leading to self-support. The Committee also called attention to the numbers of children who have defective vision due to refractive errors, impaired hearing, or dental defects, and to the need for providing proper treatment to prevent and to remedy serious impairment.¹⁵

Advances To Be Sought

During the initial period of Federal and State cooperation in providing services for crippled children a Nation-wide organization for this program was created, basic policies and procedures were developed, and large numbers of crippled children were given the remedial care they needed.

The experience of the first 3 years made apparent the necessity for further development of the program in the following directions.

Continued emphasis is needed in all phases of the program on improvement of the quality of care, including (1) direction by physicians for all State crippled children's programs, preferably

¹⁵ Part of the increased funds for grants to the States for services for crippled children authorized by the Social Security Act Amendments of 1939 (approved August 10, 1939) will be used for services for children suffering from heart disease due to rheumatic fever.

by physicians who have had pediatric and public-health training and experience; (2) development of techniques and procedures for periodic review of quality of care; (3) medical supervision by qualified pediatricians in clinics, hospitals, convalescent and foster homes, and, where possible, the child's own home; (4) improvement in the method of prescribing and supervising physical-therapy services; (5) further training for professional personnel on State and local staffs; and (6) instruction of local practicing physicians in the early recognition and prevention of crippling conditions.

More provisions should be made for service for types of crippling other than orthopedic and plastic conditions and for children of migratory families and minority groups.

Improvement in clinic service is needed to provide for reexamination as well as initial diagnosis; more effective follow-up of recommendations for treatment; more effective coordination of State and local services at diagnostic clinics; extension of the principle of planned conferences of professional personnel on an individual-case basis; and more attention to arrangement for parents to discuss the child's condition with the orthopedic surgeons or the clinic physicians or other clinic personnel so that the parents will understand what is needed for the child.

Improvement is needed in hospital and convalescent-home standards, with particular reference to the provision of more adequate medical supervision of crippled children in the hospital by qualified pediatricians; facilities for the isolation of children on admission to institutions and of those who develop contagious diseases during their sojourn and for the prescription and supervision of physical-therapy services.

Universal adoption by the States of standard birth certificates that include provisions for reporting birth injuries and congenital abnormalities is needed. Provision should be made for the reporting of acute rheumatic fever by physicians and for more effective use of public-health reports now required on meningitis, bone tuberculosis, poliomyelitis, and other infectious diseases that lead to crippling.

Studies of intake and discharge policies and court-commitment procedures are needed; of standards for convalescent and foster homes and sanatoria; of appliances; of the cost of hospital and institutional care; of services provided for crippled children by local health and welfare workers; and of the effect of low standards of public assistance on services provided for crippled children.

There is great need for further development of treatment services of the proper kind and quality for children who can be treated while living at home. To some extent it will be possible to develop more clinic centers where medical supervision can be maintained. Physical-therapy treatments can be given from such centers and community nursing services can be called on for the supervision of the child at home. In sparsely settled areas it probably will be necessary to develop consultation service by orthopedic and other specialists to local general practitioners of medicine and to provide some type of itinerant physical-therapy service or instruction of local public-health nurses and parents in physical-therapy techniques, as well as advisory service to local child-welfare workers and public-health nurses on the social and nursing phases of the home care of the crippled child. These services so strengthened will also improve the quality of after-care provided for children who have been hospitalized.

The present crippled children's program has evolved a method for bringing to families assistance in dealing with the physical handicaps of children. As the community and the Nation recognize the needs of these children, the program can be steadily expanded to prevent the incidence of crippling conditions among children and to provide the care and training necessary to mitigate their physical handicaps and to equip them for self-dependent adult life.

State Summaries of Progress, 1936-38

By June 30, 1938, most of the State agencies had had more than 2 years' experience in administering their enlarged crippled children's programs, and their patterns of administration were established. The following brief reports by State administrators reveal the character of problems met during the initial period, 1936-38, and the methods devised for rendering effective service.

ALABAMA

State agency: Department of Education, Division of Vocational Education.

During the fiscal year 1938 definite progress was made in the program for crippled children. A larger number of crippled children was reported this year than during any previous year. Undoubtedly a large number of people have become conscious of the needs of the crippled child. An increased number of cases was reported by physicians. A referral card was made for the use of the physician, and it is desired that crippled children have this card on being admitted to a clinic, although this procedure is not compulsory.

Twenty-one itinerant clinics were held—an increase over previous years—and approximately 2,334 children had their crippling conditions diagnosed or received follow-up care. The attitude toward clinics on the part of the medical profession was one of cooperation, and a clinic was held with the hearty approval of the county medical society in every center where a request was made. Such endorsement is necessary before arrangements are made for a clinic. Clinics were better organized and were held in such places as would facilitate the handling of a larger number of crippled children than previously. A competent brace maker attended every clinic for the purpose of fitting new braces for those children for whom braces were recommended. X-ray facilities were available at every clinic center. Lunches were provided by local groups at almost every itinerant clinic.

The permanent clinics, held weekly at each hospital center, made possible frequent check-up of cases and were well attended. An increased number of beds and some additional facilities were provided both in the hospitals and in the convalescent homes.

Better follow-up care was provided by the State staff and the cooperating agencies. When a child enters the hospital, a notice is mailed to each of the cooperating agencies; when he leaves the hospital, a form which gives concise information, including data on follow-up care, is mailed by the hospital to the State service. A letter is then written by the State service to the county health department, incorporating this information, and copies are mailed to the welfare and education departments. A form card is supplied by the State service for use by county health departments in reporting visits made to crippled children. County welfare workers visit children and families in their territories to help them make adjustments, to see that the child is following the doctor's orders, and to check on welfare responsibilities.

A filing plan for checking the date of return of children to the doctor was put into effect in such a way that a very large percentage of children received the proper follow-up care.

The W. P. A. teaching project for crippled children has been enlarged to provide the services of a sufficient number of teachers and teaching hours to enable children in hospitals to keep up with their studies in the regular schools. Home teaching has been carried on in the larger centers where a considerable number of children live close enough together for one teacher to visit them.

During the year occupational therapy was provided by the Junior League of Mobile for the children hospitalized in that city.

A survey was made of crippled children in every white and Negro school in the State. The superintendents, principals, and teachers were highly cooperative in this project.

The Alabama Society for Crippled Children cooperated actively with the State crippled children's service and the rehabilitation service. A county-wide committee has been organized by the society in every county in the State. A "Crippled Children's Week" was proclaimed by the Governor and was impressively observed throughout the State. The cooperation of county health, welfare, and education departments and of the county committees has been of distinct advantage to the State service.

A plan of referring to the State rehabilitation service for vocational guidance and training those children whose crippling conditions are not fully removed has worked satisfactorily. A great deal of emphasis is being placed by the rehabilitation service on the vocational-guidance program for these children, and they will be given vocational training at the proper time.

Many crippled children with spastic conditions received the services of a specialist in a school for motor re-education established in Birmingham. A great deal was accomplished for a limited number of children through this institution.

ALASKA

State agency: Territorial Department of Health, Division of Maternal and Child Health and Crippled Children.

Three important features marked the progress of the crippled children's program in Alaska during the fiscal year 1938:

1. About 150 children were reported to the central office as handicapped by some type of deformity. This is an increase over 1937 of about 100 children.
2. Administrative arrangements for transportation, hospital care, and follow-up care were more efficiently organized.
3. There was an increase in the number of cases cared for (13 in 1938 as compared with 8 in 1937).¹

Reporting of the handicapped children unfortunately still depends largely on—

1. School teachers of both the Territorial and Government schools (Office of Indian Affairs).
2. The Government nurses.
3. United States Commissioners.

The public-health nurses and the practicing physicians are on the alert for locating children with such deformities, but the majority of patients live in isolated districts where a case remains undiagnosed until the deformity is so evident that it is recognized by the "village trader." Little progress was made in obtaining medical diagnosis for these cases reported from isolated interior districts. The acting director of the Division of Maternal and Child Health and Crippled Children was able, in her field work, to examine some of these patients in southeast Alaska, but she could not reach many of the small villages in the west and north.

¹All children requiring surgical care are transported to Seattle, Wash.

Throughout the Territory there is an ever-increasing knowledge of the care offered under the crippled children's program, and the reporting of children in need of care has improved. It is most unfortunate that, because of a limited budget, care can be offered to only a few children. The sense of futility in reporting is somewhat lessened but is still in existence.

The administrative arrangements for transportation have gradually been made more efficient. The family often provided part of this cost. Free transportation on Government boats is available only at irregular intervals and at irregular ports of call, but is used whenever possible.

Definite contracts were made for payment for services of orthopedic surgeons in the States. Reports from the Children's Orthopedic Hospital in Seattle, Wash., on the progress of the child under treatment, as well as a summary of the case and recommendations for aftercare, have been requested and are regularly received. The Territorial public-health nurses and the Government nurses are instructed as to these recommendations, and their reports on the home treatment of the discharged cases have been requested.

ARIZONA

State agency: Board of Social Security and Public Welfare, Division for Crippled Children.

The fiscal year ended June 30, 1938, was an outstanding year in the history of the crippled children's program in Arizona. During this year a substantial increase in funds was provided by the State legislature, and the Pima County board of supervisors made the necessary changes in the hospital already under construction. This resulted in the provision of three attractive wards for crippled children and a physical-therapy department whose facilities include a treatment pool. The Division for Crippled Children was given technical supervision of this department, and a physical-therapy technician from the State-agency staff has been assigned to this program.

A convalescent home with a graduate nurse in charge has been established in Phoenix, which is the largest treatment center. The home is a roomy, well-built structure with ample, attractive grounds, in a very good location 7 miles from the center of Phoenix. In addition to regular home care, services include a certified teacher and a nurse to take the children to and from the hospital and clinic. Handicraft and music are taught by special teachers. The children are frequently guests of the local theater manager and are invited to practically all special children's parties planned by the local school, Sunday schools, and clubs. The regular school bus calls for all who are able to attend school, and kindly neighbors and friends take them to Sunday school in their respective churches.

Only children who are receiving active treatment and who live at a distance too great to permit adequate care are placed in this convalescent home. Where home conditions are such that placement of the child elsewhere is necessary, he is referred to the Child Welfare Division for service.

The convalescent home in Tucson, which is really more like a "junior" hospital, has a graduate nurse on duty both day and night. Almost all the children placed there require bed care but do not need intensive hospital care.

As the cost of care in these homes is less than half the regular hospital charges, it has been possible to care for many more children. These homes have been made possible through cooperation with many local groups. Practically all the furnishings have been provided by such groups.

The Arizona Society for Crippled Children has set up a fund for the maintenance of older crippled children who otherwise would not be able to take advantage of higher education or vocational training. The National Youth Administration also is assisting in the educational program.

Transportation for children to and from treatment centers and clinics, travel expenses of teachers and of a nurse, numberless pairs of new shoes, clothing, material for handicraft, books, musical instruments (including a piano), and many other items have been provided by interested lay groups. These same groups are also giving a great deal of service, thereby eliminating the need for several paid employees.

Extension and improvement of the services rendered directly by the State agency have been made possible through employment of a field consulting staff consisting of an orthopedic nurse, a medical-social worker, and a physical therapist.

Development of community interest and resources and the extension and improvement of crippled children's services as provided for in the annual plan have been the outstanding activities during this fiscal year.

ARKANSAS

State agency: Department of Public Welfare, Crippled Children's Division.

The Crippled Children's Division of the State Department of Public Welfare was organized on July 1, 1937. The first patient was accepted in the Little Rock General Hospital on September 1, 1937. Since that time patients have been accepted regularly for treatment.

During the summer of 1937 there was an extensive epidemic of poliomyelitis in the State. Realizing the necessity of early treatment, the Crippled Children's Division accepted all indigent children who had had the disease during the epidemic. These patients were accepted on the recommendation of their family physician or the county health officer and were not compelled to wait for a diagnostic clinic. Children up to 21 years of age were accepted.

At the beginning of the program only two hospitals were used. Since that time, however, four others have been used. The doctors on the staff include three orthopedic surgeons and one plastic surgeon in Little Rock, one orthopedic surgeon in Pine Bluff, and a specialist in arthritis in Hot Springs. There are four pediatricians on the regular staff. Consultants in other fields of medicine are called when needed and are paid on a fee basis.

A policy was established whereby all cases must be seen at a diagnostic clinic by an orthopedic surgeon before they can be placed on the waiting list. The only exception to this ruling was emergency cases—children suffering from acute poliomyelitis, acute osteomyelitis, or acute suppurative arthritis, and infants with harelip or clubfoot.

The Crippled Children's Division made arrangements with railroad, bus, ambulance, and taxicab companies for transportation of patients at reduced rates. The Division paid for transportation to and from the hospitals but did not pay transportation to and from clinics. If the families were able to pay for this service, they were requested to do so.

There is no State-owned brace shop in Arkansas. Two shops have been used for braces. Representatives from these shops attend each clinic and, when braces are all that is recommended for a child, measurements are taken at the clinic under the direction of the examining surgeon. When the braces are ready, the child is called in to be fitted and the brace is approved by the surgeon who examined the child at the clinic. Artificial limbs are provided in the same manner.

A convalescent home for white children up to 16 years of age was established by a registered nurse in October 1937. This home, staffed entirely by trained nurses, can take care of as many as 20 to 25 children.

A convalescent home for Negro children was used for a time, but this home could not maintain the required standards and has been discontinued.

Three foster homes for white children were established through the cooperation of the Child Welfare Division during 1938.

The Crippled Children's Division had cared for 421 cases at the end of the fiscal year.

CALIFORNIA

State agency: Department of Public Health, Crippled Children's Services.

As it now operates, the program of aid for crippled children in California is carried out in two ways: (1) Direct services, such as diagnostic clinics, hospitalization, and aftercare of crippled children, administered by Crippled Children's Services; and (2) indirect services, which are established where local county programs for crippled children can be supervised and expanded through the use of additional funds.

These services are offered crippled children under the provisions of the California Crippled Children's Act of 1927, which defines a crippled child as a "physically handicapped child" and limits the application of the act to those under 18 years of age. However, children up to the age of 21 years are eligible for care under the Federal social-security program.

In each county that gives services to crippled children within the county jurisdiction and whose standards of care have been approved, the director of the State Department of Public Health appointed a special agent who is responsible, in a liaison capacity, for the administration of the services.

Some local units also appoint a professional advisory committee. This committee must approve the medical reports and recommendations for care of crippled children before such reports are submitted to the director of the State Department of Public Health for his approval. Where no local professional advisory committee functions, the unit makes use of the State professional advisory committee.

The personnel working in local programs and under supervision of Crippled Children's Services includes 43 public-health nurses, 6 nurses in hospitals, 2 welfare agents, 2 county physicians, 4 social workers, and 1 physical-therapy technician.

In those counties where the program is not administered directly by Crippled Children's Services its representatives visit and inspect facilities for locating and caring for crippled children in order to maintain uniform standards of care throughout the State. These visits and inspections are made at intervals of approximately 3 months.

Crippled Children's Services also makes arrangements whenever possible to provide facilities for the care of crippled children where adequate local staff is lacking.

Besides the local units with which Crippled Children's Services works in an advisory capacity, there are other State departments and organizations with which the services are developed cooperatively. These include the Division of Child-Welfare Services, State Department of Social Welfare; Bureau of Vocational Rehabilitation, State Department of Education; service clubs; and women's organizations.

Among many accomplishments during the formative period were the completion of plans for a State register of crippled children and diagnostic clinics and the selection of hospitalization centers. Fee schedules also were worked out for hospitalization charges and specialists' charges for professional services, as well as charges

for convalescent care, foster-home care, appliances, and other services. This work was accomplished with the assistance of the members of the professional advisory committee, other private physicians, and individuals in charge of hospitals and convalescent homes.

In short, during this 2-year period, the ground work for the program was laid by the chief of the Crippled Children's Services, with the guidance and under the supervision of the director of the State Department of Public Health and with the assistance of professional and lay advisory committees and of public and private agencies interested in furthering the crippled children's program in the State.

Under the present plan Crippled Children's Services is responsible for the following activities:

1. The registration and filing of all known cases of crippled children under the age of 21.

2. The examination of crippled children admitted to diagnostic clinics held in counties throughout the State.

3. The classification, through public and private agencies, of those children whose parents are unable to provide proper care either in whole or in part; of those who may receive care through local agencies; and of those who require hospitalization and surgical care under the provisions of this program.

4. Medical care, nursing, physical therapy, aftercare, and supervision for all children requiring corrective measures.

5. Supervision of all local programs for the care of crippled children.

6. Formulation of a program for the prevention of deformities whenever possible.

7. Formulation and supervision of an educational program for parents, professional and lay groups, health officers, and other official agents.

8. Strengthening of existing organizations for the care of crippled children throughout the State and use of new organizations or facilities whenever these meet the required standards.

As a part of the plan to register and file names of all known cases of crippled children, a State register was set up in the central office in San Francisco. This register will give as much factual identifying information concerning the type of handicap and the medical and social background as may be obtained from the diagnostic clinics held by Crippled Children's Services and from the Bureau of Vital Statistics, Bureau of Child Hygiene, Bureau of Tuberculosis, public-health and school nurses, private physicians, hospitals, educational agencies, lay groups, interested individuals, and an interdepartmental system of reporting cases. The register will make it possible to check on all cases of crippled children in the State, whether they are in need of medical treatment or are under private or public medical care. The central office will thus be a clearing agency for tracing and verifying histories and records desired by all organizations working for crippled children.

To make the records more complete and to have available exact information concerning each crippled child cared for by Crippled Children's Services, photographs of each patient requiring treatment are taken when the diagnostic clinic is held or when a specialist first examines a patient. As treatment progresses, subsequent photographs are taken to illustrate corrections accomplished through orthopedic or plastic surgery or other types of care given crippled children.

Diagnostic clinics are held in counties throughout the State when the number of crippled children warrants the organization of such clinics. Usually the

clinics are in communities far removed from hospitalization centers. They are held at intervals of 6 months, if there are enough cases under treatment or supervision to warrant holding repeated clinics.

The personnel for the clinics includes an orthopedic specialist, a public-health nurse, a medical-social worker, and a stenographer. The clinician may be assisted by a plastic surgeon, an ophthalmologist, an orthodontist, a pediatrician, or some other specialist, depending upon the types of cases to be examined. Lay assistance is always available through the work of interested volunteers, who materially assist in conducting the clinics.

Attendance at the clinics averages 43 patients. Additional clinicians are appointed if the known or estimated number of patients to be admitted is more than one clinician can adequately examine. Time is allowed during the hours of the clinic to give parents an opportunity to discuss the recommendations made by the specialists.

Much interest in these diagnostic clinics has been shown by private physicians. They have brought some of their patients for diagnosis and often were so keenly interested in the work of the clinicians that they remained to observe and discuss the treatment recommended. In this manner expert and up-to-date techniques are made available to private physicians in the more rural communities.

After a clinic has been held, follow-up work is begun by the medical-social worker in conjunction with health and welfare agencies and interested and responsible persons in the community. This work consists chiefly of arranging for the care recommended by orthopedic or other specialists, which includes provision for treatment—hospitalization, surgery, or supervision; for braces or other appliances; for appointments; and for transportation to and from medical centers. When patients return to the community it is often necessary for the field workers to arrange for home treatment and sometimes for the return of patients to the hospital for further treatment.

Records of the medical findings and recommendations, made when the diagnostic clinics are held, as well as subsequent reports of medical care, progress of the patient, and recommendations, are made in duplicate and are forwarded to the county health officers and to the public-health or school nurses concerned with the care of the crippled child.

COLORADO

State agency: Division of Public Health, Division of Crippled Children.

The fiscal year 1938 was marked by an almost continuous state of emergency in Colorado. The Division of Crippled Children was hampered continuously by a lack of personnel. Qualified field personnel were not available, and clerical service was hampered by changes and delays in appointments. At the same time the Division had to face the most widespread epidemic of infantile paralysis that the State has known, with hospital resources not developed to meet such an emergency and community and local workers not yet fully familiar with the plan of operation. In view of these handicaps it was gratifying to be able to make progress and to meet the emergency as adequately as was done. Contact was made directly with the 237 patients placed under treatment under the auspices of the Division of Crippled Children, and the other cases were provided for by other agencies and by private physicians.

Orthopedic surgeons carried an unusually heavy load during the year, and hospitals made every effort to meet the need. Two hospitals added trained physical-therapy technicians to their staffs, and three added materially to their

equipment. Two of the hospitals have established model pediatric wards, and two hospitals provided for special postgraduate work for their pediatric supervisors.

With respect to relationships with public and lay agencies, foundations laid in the first year of work were built upon slowly but actively. Generalized instructions concerning regulations and procedures, given largely by direct contact during the first 10 months of operation (during which time the State was canvassed and served by clinic areas), were crystallized in bulletin form and sent to medical, nursing, welfare, educational, and some lay agencies, with a report of the first year's services. These written instructions were supplemented by individual assistance given by the field staff, every opportunity being taken to foster coordination of the various services and to prepare foundations for future improvement. An increase in interest and participation on the part of public-health nurses and welfare staffs has been noticed, which opens the way for further improvement in these services.

Medical understanding and participation have shown marked and satisfactory development. The State medical society has continued its interest, and an increasing number of local physicians have expressed approval by direct word and by referring more children for registration and for treatment. In two areas where medical groups had been reluctant to join with the program, approval of the program and desire to participate have been expressed. This advance means that the service is now active in every part of the State.

CONNECTICUT

State agency: Department of Health, Bureau of Child Hygiene, Division of Crippled Children.

The field organization of the crippled children's program for Connecticut began on September 1, 1937, with the appointment of a physician as chief of the Division of Crippled Children. The first steps in organization were the selection of five suitably located hospitals to serve as clinic centers and the appointment of a qualified orthopedic surgeon to head each clinic. In choosing locations for the diagnostic clinics, an effort was made to avoid duplication of already existing facilities for the care of crippled children, and yet to make at least one State clinic accessible to every part of the State.

The crippled children's technical medical advisory committee of the Connecticut Medical Society cooperated in the selection of orthopedic surgeons and of other professional personnel for the program, such as plastic surgeons, pediatricians, and urologists; in the designation of locations for the clinics; and in the establishment of a schedule of fees and rates for services rendered to crippled children under the State program. The fee schedule provided for medical and surgical services to crippled children at a nominal professional charge, and the rate schedule established remuneration for hospital services on a basis close to actual cost. Arrangements were made also with private brace makers and shoemakers to fill orders from the Division of Crippled Children, usually at substantial reductions from customary charges.

Concurrently with steps taken in the organization of the State program, efforts were made constantly to acquaint the public as well as the medical and nursing professions with the objectives and policies of the program. Publicity of this character was carried on through newspapers, weekly and monthly bulletins of the State Department of Health, circular letters of information to doctors and nurses, and addresses to professional and lay groups.

Actual services to crippled children were begun in February 1938, at which time two of the diagnostic clinics opened; the remaining three clinics opened in March.

Immediate advantage was taken by the public of the services offered. In February, 41 children reported; in March, 80 additional children were seen at the clinics; and in April, 89 more children came in search of help. During the next 2 months 104 additional children reported to the clinics, making a total of 314 cases examined during the first 5 months of operation of the program.

These patients were referred to the State clinics by licensed Connecticut physicians and were brought in by public-health nurses, social workers, parents, and sometimes by the physicians themselves. The great majority of the children examined (nearly 5 out of every 6) were in need of some type of service offered by the State program. The number of serious conditions is indicated to some extent by the fact that more than a quarter (85) of the total number of children in need of care were recommended for hospital treatment—usually an operation—by the examining orthopedic surgeon. The average hospital stay was 22 days.

Children not in need of hospital treatment required physical therapy in a great number of cases. It was originally planned to treat these children through the facilities of institutions employing physical therapists, but the demand for physical therapy has so far exceeded the available supply that it has been found necessary to provide supplementary physical-therapy services through State-employed technicians. At the close of the fiscal year two full-time physical therapists were to be added to the staff of the Division of Crippled Children in the near future to treat crippled children 1 or 2 days a week in each of the hospitals where the diagnostic clinics are held.

A medical-social worker was added to the program on April 1, 1938, and arrangements were made with local and State agencies to provide various types of case-work services: Aid in making home and family adjustments; transportation; education; vocational training; and services to meet welfare and health needs in general. A financial investigation is made in all cases, and children who are ineligible for aid under the State program for financial or other reasons are referred to a resource qualified to handle the problem involved.

The State agency is especially indebted for the success of the program to family doctors for referral of cases, to local nurses for discovery and follow-up of patients, to the superintendents of the clinic hospitals for the wholehearted manner in which they have given of their facilities and their personnel, and to the generous and at times enthusiastic cooperation given by communities throughout the State to the work of the Division of Crippled Children.

DELAWARE

State agency: Board of Health, Services for Crippled Children.

A crippled children's program was instituted by the State Board of Health on October 15, 1937. A selected nurse had previously received special training in Boston to qualify her for field supervision.

Her first step was to make contact with every physician in the county in which the service was started. All physicians in this county have proved very cooperative. Diagnostic clinics were opened at three points. Investigation was begun of a list of some 400 names reported by the National Youth Administration and other agencies. A register of crippled children was established.

By arrangement between the State Board of Health and the Nemours Foundation, Services for Crippled Children is assuming responsibility for case finding, diagnosis, aftercare in the home, and general field work. The Foundation undertakes to pay the costs of treatment, up to \$75 per case, for patients who, in the judgment of the clinician, are in need of hospital care and medical or surgical treatment.

Prevention and early correction of injuries present at birth are now largely the responsibility of the State generalized nursing program, through prenatal care and inspection of the newborn infants at the time a copy of the birth certificate is given to the mother. A leaflet on prevention of crippling from infantile paralysis, prepared in cooperation with the Nemours Foundation, has been issued.

DISTRICT OF COLUMBIA

State agency: Health Department of the District of Columbia, Bureau of Maternal and Child Welfare.

The administration of services for crippled children in the District of Columbia was transferred from the Board of Public Welfare to the Health Department on July 1, 1937, and the administrative responsibility for this program was placed in the Bureau of Maternal and Child Welfare.

The major features of the program, plans for which were worked out during the year, are as follows: (1) The addition of a question on the birth record for reporting birth injuries and congenital abnormalities; (2) the utilization of the existing child-hygiene centers and the school medical-inspection and nursing services for locating crippled children and for screening examinations; (3) the establishment of a diagnostic and ambulatory-treatment center at Gallinger Municipal Hospital and the utilization of wards in Gallinger and the Children's Tuberculosis Sanatorium at Glenn Dale for children needing hospitalization, as well as of Children's Hospital and Emergency Hospital for hospital and clinic care; (4) the development of plans to provide in suitable institutions outside the District long-time institutional care of a kind not available in the District of Columbia; (5) arrangements for follow-up in the home through the field nursing service wherever possible; (6) the development of a medical-social service; (7) the extension of physical-therapy service in the wards and clinic at Gallinger Municipal Hospital and in the crippled children's schools; and (8) the formulation of plans for coordinating activities for crippled children in the District.

The major accomplishments during the year were associated with the concrete working out of details of the plan and the initiation of a study of facilities and needs, particularly in relation to the aftercare of crippled children who have been hospitalized at public expense since July 1936. This study revealed marked inadequacy in aftercare and pointed clearly to a need for more adequate post-hospital follow-up and additional clinic facilities. At the end of the fiscal year plans were definitely under way for providing the needed facilities and personnel.

FLORIDA

State agency: Crippled Children's Commission.

The Crippled Children's Commission felt that progress was made during 1938 in that more children were hospitalized, better services were rendered, and a more complete program was developed.

A better spirit of cooperation was manifested between the Commission and the social-welfare organizations in that all children discharged from hospitals and convalescent homes were referred to the State Board of Welfare, which then undertook to visit these children in their homes in an effort to make such improvement as was possible in their surroundings. These children were also referred to the nursing service of the State Board of Health, and the nurses in their respective localities visited the children in their homes and rendered such professional services as were possible. The nurses also saw that instructions given in regard to particular cases were carried out.

The public was informed of the work being done at the clinics and hospitals by newspaper articles and talks by the surgeons and field nurses before civic clubs and schools.

The field nurses made contact with the parents of former patients when a clinic was to be held in a locality and also informed the public so that each out-patient clinic was well attended. These clinics were held for diagnostic purposes only, but X-ray photographs were taken and appliances and braces fitted when necessary.

Former patients were seen at the clinics and the surgeon prescribed whatever measures might be of benefit to the children without their returning to the hospital, thereby oftentimes saving a trip to the hospital for the child. The field nurses also kept in close contact with the children after they were returned to their homes and noted and reported progress to the orthopedic surgeon.

The three convalescent homes used by the Commission were all improved in many ways; they added to their personnel, enlarged the buildings, and rendered more efficient service. Schools were maintained in each convalescent home in order that the children might continue their schooling. These schools were maintained at no expense to the Commission. Many children were referred directly from the hospitals to the director of vocational rehabilitation.

The State register is being revised and will be maintained in the office of the Crippled Children's Commission at Tallahassee.

Reciprocal agreements were made with the States of Georgia, Alabama, and New Jersey, and excellent cooperation was established with patients moving to these States from Florida. The Commission is eager to establish reciprocal agreements with all States in this service.

GEORGIA

State agency: Department of Public Welfare, Crippled Children's Division.

Immediately after a skeleton State staff had been organized, a list of crippled children, located through a W. P. A. survey made in 1937, was sent to each county welfare department and plans were made for diagnostic clinics to be held in various sections of the State.

Between the initiation of the program April 1, 1938, and the end of the fiscal year, June 30, 1938, 25 clinics were held in the several congressional districts, covering 156 of the 159 counties in the State. About 7 or 8 counties participated in each clinic. Each participating county brought from 6 to 8 children for examination. At this series of clinics approximately 800 children were examined by the orthopedic surgeons participating in the program.

On April 15 the first child was admitted for hospitalization, and thereafter until July 1, 1938, hospitalization at various hospitals throughout the State was authorized for 156 children from approximately 130 counties.

The nursing and social-service field personnel was not organized until the last month of the fiscal year, but district headquarters were designated for the field personnel so that their work could be actively undertaken at the beginning of the new fiscal year. During the month of May three nurses were given advanced orthopedic training and a "refresher" course in orthopedic work at the Scottish Rite Hospital in Decatur. These nurses were later placed in the field to follow up hospital cases returned to homes.

During the first 3 months of the program convalescent service was developed in Atlanta, where a home was set up temporarily to take care of 8 patients. Later a dwelling was secured which offered facilities for 20 convalescent patients. The personnel of this home is under the direct supervision of a graduate nurse, with

practical nurses and orderlies as assistants. The home is located within the city limits of Atlanta and is easily accessible to the various hospitals and participating orthopedic surgeons. Physical therapy is carried out in the convalescent home by a trained physical therapist. Arrangements were being made in Augusta, Savannah, and Macon to maintain children under convalescent status in the hospitals, as it was found that there were not sufficient numbers of convalescent children in these cities during the early part of the program to justify the maintenance of convalescent homes. This arrangement has worked out satisfactorily. The possibility of opening a convalescent home in Columbus was being considered at the close of the fiscal year.

Outstanding cooperation was received from the beginning of the program from local and county officials, church and civic organizations, local physicians, and interested individuals. A statement outlining the purposes, plans, and organization of the crippled children's program was sent to local newspapers throughout the State. Daily newspaper articles were published concerning the clinics held throughout the State, and a radio address was given by the State director outlining the purposes of the program.

HAWAII

State agency: Territorial Board of Health, Division of Services to Crippled Children.

During the fiscal year 1938 a broader interpretation was given to the definition of a crippled child so as to include more types of crippling conditions. Eye cases were accepted when surgery could be expected to improve vision. Children with cleft palate and harelip were given orthodontic and other services, in order to rehabilitate them more completely.

The administration of this division was delegated by the Territorial Commissioner of Public Health to the deputy health officer, as director of services for crippled children. Other professional personnel consists of two orthopedic nurses, one of whom was a public-health-nurse trainee during the year at Columbia University. Her position was temporarily filled by a public-health nurse. The position of medical-social worker was included in the budget, but no qualified person was available.

All specialists assisting in the program are paid on a case basis.

As the program developed, working policies and procedures were clarified and planned with many cooperating agencies. In the official State agency a closer working relationship in the administration of the nursing program was worked out with the director of the Bureau of Public Health Nursing.

Conferences were held with the staff of Shriners' Hospital for crippled children in order that its program could be extended, improved, and assisted by this Division. Social investigations by the Territorial Board of Public Welfare were thoroughly discussed and planned by the directors of these two agencies, and the crippled children's program was explained to their workers. The program for eye work was greatly assisted by a cooperative policy adopted by the Bureau of Sight Conservation and the Territorial Board of Health.

A great deal of effort and time was expended with the hospitals utilized by the official agency in this program in planning fee schedules, facilities, records, and personnel. Meetings were held with the county and Territorial medical societies, with the technical advisory committees, and with the Hawaii Dental Society to discuss the program in detail and the need for their cooperation.

The Department of Public Instruction cooperated in the provision of special educational facilities for crippled children. The special speech class sponsored by both agencies and the special crippled children's class in one local school in Honolulu are excellent examples of the part the Department of Public Instruction

plays in the education of crippled children. The Division of Vocational Rehabilitation of the Department of Public Instruction carried along special training and rehabilitation of crippled children showing aptitude.

Other accomplishments of the year were the establishment of the diagnostic clinic for crippled children in the building occupied by the Board of Health; the establishment of a private convalescent home supervised by this official State agency; the beginning of the enlarged special speech class for children with post-operative harelip or cleft palate; the completion of plans for the generalization of the public-health-nursing program for crippled children, applicable to all the islands; and the numerous educational releases in local newspapers and in the magazine, "The Crippled Child." Informal talks were given by the director and the orthopedic nurses. Office procedures, follow-up records, and statistics were improved during the year.

IDAHO

State agency: Department of Public Welfare, Division of Public Health, Bureau of Maternal and Child Health and Crippled Children.

The progress achieved in the crippled children's program in Idaho during the fiscal year 1938 was steady though not spectacular.

A gratifying aid to the crippled children's program came with the extension of full-time public-health supervision to five additional counties. This has resulted in marked improvement for these counties in education of the public regarding the crippled children's program, in case finding, in clinic organization, and in aftercare services by public-health nurses.

During the fiscal year a complete review and analysis of the previous expenditures of funds available for the care of crippled children and the number of crippled children treated resulted in changing payment of the orthopedic surgeon, the plastic surgeon, and the pediatric consultant from a fee-schedule basis to a part-time salary basis. It was also agreed that the surgeons should provide necessary assistants with the exception of the anesthetists. This change not only has simplified accounting but has enabled the agency to arrange financially for the treatment and hospitalization of all children eligible under this program, which was not formerly the case.

During the latter part of the fiscal year the assistant director of the crippled children's program since its inception took a 6-month course in medical-social work at the University of Chicago.

A State orthopedic advisory nurse was selected and sent to Simmons College, Boston, for advanced training in orthopedic nursing. Upon her return she will assist in (1) in-service education, (2) follow-up services, (3) advice to official and nonofficial nursing agencies, and (4) diagnostic and follow-up conferences.

A well-qualified physical-therapy technician was added to the State staff to provide physical therapy for crippled children in hospitals and foster homes and to assist in the diagnostic and follow-up conferences.

The problem of supplying teachers for convalescent patients was met when the W. P. A. Adult Education Department agreed to supply grade-school and high-school teachers to visit the hospitals and foster homes and give this important service.

Through cooperation with the State child-welfare supervisor, standards for convalescent and foster homes were set up, and child-welfare consultants are working with the Bureau of Maternal and Child Health and Crippled Children in locating, investigating, and certifying homes used for care of crippled children under this program.

ILLINOIS

State agency: Department of Public Welfare, Division for Handicapped Children.

The Division for Handicapped Children in the State Department of Public Welfare was completely organized during the fiscal year 1938. The Surgical Institute for Children, a division of the Research and Educational Hospitals of the University of Illinois College of Medicine (a State hospital, operated by the Department of Public Welfare), increased its bed capacity from 80 to 140 beds during the fiscal year. The Division for Handicapped Children, located with the general office of the Department of Public Welfare in Springfield, administers the program for crippled children and supplies public-health nursing, social service, and orthopedic field clinics in the State of Illinois, exclusive of Cook County.

Activities carried on during the year included a State-wide case-finding census (completed in 43 counties and partially completed in 52 of the 102 counties of the State) and orthopedic clinics for children handicapped by orthopedic and plastic conditions.

Sixty clinics were held in 30 communities during the year. Of the total registration of 2,174 patients in the Division for Handicapped Children (as of June 30, 1938) 1,744 were seen in the clinics. Of the latter number, 783 were recommended for hospital care. By the end of the fiscal year this recommendation had been carried out for 357 (46 percent). The following appliances were furnished directly to patients attending the clinics: 138 braces, 39 artificial limbs, 184 orthopedic shoes and shoe corrections.

Progress was made in the early location of patients with conditions which lead to crippling, through dissemination of an illustrated pamphlet with each birth-registration certificate (120,000 copies of this pamphlet were distributed). This was made possible by a cooperative agreement with the Division of Vital Statistics of the Illinois State Department of Public Health. A colored and perforated front sheet was devised that will shortly be placed in each birth-certificate book in order to arrange for direct reporting of congenital deformities to the Division for Handicapped Children.

A State-wide follow-up of poliomyelitis cases from the 1936 and 1937 epidemics was carried out by the field nurses and the district health officers of the Illinois Department of Public Health. Every case of residual paralysis from poliomyelitis in Illinois, exclusive of Cook County, from the 1936, 1937, and 1938 epidemics is being brought under care, the majority being under supervision of orthopedic surgeons.

Respirators owned by private organizations throughout the State have been counted and listed. Seven new respirators were purchased from the Governor's contingent fund, to be placed at the joint command of the Division for Handicapped Children and State hospitals of the Department of Public Welfare. This last item completes a State-wide program for the specialized supervision of cases of poliomyelitis.

INDIANA

State agency: Department of Public Welfare, Services for Crippled Children.

During the fiscal year 1938 the crippled children's program in the State of Indiana began to function along the lines anticipated. Early in the fiscal year a manual for the administration of services for crippled children was prepared, including necessary forms to make possible the acceptance of crippled children for services by county and State departments of public welfare.

As many crippled children in Indiana were receiving treatment under

the county commitment system which has prevailed since 1921, arrangements were made by the county departments with county judges having juvenile jurisdiction to transfer many of these children to the supervision of the State Department in order that a coordinated State plan of services for crippled children might be developed.

In November 1937 the South Bend Hospital Center was first used by the State agency, and a medical-social worker was placed on the staff of the hospital center. At that time the two local orthopedic surgeons were appointed agents of the State Department and began their work with crippled children in the northern area of the State. Early in November a medical-social worker was added to the staff of the James Whitcomb Riley Hospital. During the year a special project concerned with the care and treatment of children suffering from cerebral birth palsy was also initiated at the same hospital.

Early in the year 1938 blanks were distributed to physicians for the reporting of children with congenital deformities, and arrangements were made with the State Board of Health to incorporate such forms in regular booklets distributed by the State Board of Health for the reporting of births.

In January 1938 the first orthopedic nurse was added to the State staff; by March four nurses were on the State staff.

After a period of in-service training to become familiar with the program as conducted by the State Department of Public Welfare, the nurses were sent into the field April 1. Between April 1 and June 30 arrangements were made by the nurses and the State staff for setting up and conducting 9 orthopedic consultation services at which more than 400 handicapped children were seen by orthopedic consultants selected and approved by the State Department of Public Welfare.

IOWA

State agency: Board of Education, Crippled Children's Services.

Ten mobile clinics were held in Iowa during the fiscal year 1938. Patients were drawn from 33 counties to attend these clinics. The area covered represents 21 percent of the population of the State. At these 10 clinics 1,243 patients under 21 years of age were seen, of whom 478 had received no previous treatment.

Approximately 50 physicians attended these clinics as observers, either all or part of a day. Since these clinics were held, 10 to 12 percent of the patients discovered have been committed to the university hospital for a program of treatment. Nearly all these patients belong to the low-income group. No figures are available to show how many of the remaining patients sought treatment elsewhere, as the disposition of the patient after a mobile clinic is decided by the local physician who referred the case. Disposition is made on the basis of a letter to the local physician from the orthopedic surgeon who examined the patient at the mobile clinic. This letter contains the history, social data, physical findings, X-ray readings, and indications for treatment. These letters are prepared in the central office of the mobile clinic.

During the fiscal year a definite increase in interest and cooperation was shown by the local physicians, other interested agencies, and individuals. More physicians attended the clinics than during the previous year.

A pamphlet for the home care of spastic paralysis was prepared by the assistant director. This pamphlet is given free to all individuals concerned with the care of spastic patients.

The convalescent home in Iowa City, the maintenance of which is a part of the State program, admitted 254 patients during the fiscal year. The length of time spent at the home varied from 1 week to 9 months. The home has a capacity of 25 beds. Eighty-five percent of the patients in the convalescent home received

physical therapy in some form. All patients except infants received occupational therapy.

The patients cared for in the convalescent home were selected from those patients discharged from the department of orthopedic surgery of the university hospital, who continued to need observation for an indefinite period.

Occasionally physicians requested consultation in orthopedic cases. Such consultation was usually rendered in the office of the physician by a member of the orthopedic staff.

All handicapped children seen in the mobile clinics are reported to the State Board of Education. Individual children physically unable to attend school and therefore in need of a home tutor are reported, as are those needing transportation to school. There is close cooperation between the crippled children's administration and the State Department of Health, which reports to the mobile-clinic office all congenital deformities reported to it on birth certificates.

Various members of the State staff appeared before professional and lay groups, acquainting them with the State program. The two field nurses presented the State program to visiting nurses' associations throughout the State.

KANSAS

State agency: Crippled Children Commission.

In 1931 the Kansas Legislature passed the crippled-children law creating the Crippled Children Commission composed of five members appointed by the Governor to serve for a period of 4 years without salary or compensation. It is the duty of the Commission to approve or disapprove, at its discretion, hospitals, convalescent homes, boarding homes, and charges for necessary supplies, treatments, and operations; and to have general supervisory authority over the administration of work for crippled children in the State.

Since the passage of the law the Commission has approved 19 hospitals in the State for treatment of harelip, cleft palate, and congenital cataract, and for orthopedic work. There are 11 orthopedic surgeons on the staffs of 15 of these hospitals; also 1 plastic surgeon, 9 eye surgeons, and 4 surgeons with special proficiency in the handling of harelip and cleft-palate cases.

In 1936 six public-health nurses and one field representative were employed and engaged in case finding and follow-up services over the State.

During the fiscal year 1938, 15 diagnostic clinics were conducted in which 945 examinations of crippled children were made. There were 588 crippled children who entered approved hospitals for the first time under the provisions of the crippled-children law between July 1, 1937, and July 1, 1938. Of this number, 539 were diagnosed as having orthopedic conditions or deformities, 44 as having harelip or cleft palate, and 5 as having congenital cataract. More than 1,100 children who had been committed to hospitals prior to July 1, 1937, returned during the fiscal year for check-up or further treatment.

In order to insure the proper functioning of the crippled-children law, the Commission endeavored to inform and interest the general public through community programs. During the fiscal year seven public dinner conferences were held in various parts of the State in connection with clinics. Each of these was arranged through the united efforts of the local chamber of commerce, service clubs, and women's clubs. Prominent citizens appeared on the program with either the chairman of the Commission or its legal adviser. At each meeting the State crippled children's program was described, and the functioning of the crippled-children law was explained. Open forums followed these talks, thus giving the local people an opportunity to ask specific questions. Local people were urged to enlist in the campaign for the eradication of crippling conditions.

KENTUCKY

State agency: Department of Health, Crippled Children Commission.

	Fiscal year ended June 30, 1937	Fiscal year ended June 30, 1938	Increase (+) or decrease (—)
Individual cases handled.....	1,080	1,161	+81
New cases.....	534	533	—1
Previously treated cases.....	546	628	+82
Admissions and readmissions to hospitals.....	1,420	1,792	+372
Per capita cost.....	\$156.09	\$146.78	—\$9.31
Number of itinerant and annual clinics.....	27	24	—3
Examinations at itinerant clinics.....	2,153	1,930	—223
Examinations at permanent clinics (weekly and monthly).....	562	664	+102
Total clinic examinations.....	2,715	2,594	—121

The figures above, comparing the fiscal years 1937 and 1938, show that 81 more patients were treated in 1938 than in 1937, but a more significant figure is the 372 more admissions and readmissions to hospitals. Patients once admitted for treatment must frequently be readmitted for varying periods of care. This necessarily cuts down the number of new patients whose applications can be approved. An increase occurred in the number of previously treated patients admitted for further care. It is gratifying to note that the per capita cost of treatment (for individual cases) was \$146.78 in 1938 as compared with \$156.09 in 1937, a decrease of \$9.31.

Clinic examinations in 1938 showed a decrease of 121 as compared with 1937. Although there was a decrease in the number examined at the itinerant clinics, an increase of 102 occurred in the number examined in the weekly or monthly clinics. It is the policy of the Crippled Children Commission to encourage the follow-up of cases by regular examination in the permanent clinics.

The major features of the crippled children's program in Kentucky are the holding of diagnostic clinics in sections where they are considered to be most needed, the hospitalization and treatment of as many cases as possible as soon after examination as finances permit, and as consistent aftercare service as the small staff can provide. Progress was made along all these lines during the fiscal year. As usual the chief handicap is lack of funds to treat and follow up the many cases on the waiting list.

LOUISIANA

Note.—The first State plan for Louisiana, approved on March 24, 1939, was administered by the Board of Health, Division of Maternal and Child Health. The State agency now is the Department of Health, Division of Preventive Medicine, Section of Crippled Children.

MAINE

State agency: Department of Health and Welfare, Bureau of Health, Division of Services for Crippled Children.

The crippled children's program as it operates in Maine can be divided roughly into the following major activities: Location of patients, clinic service, hospitalization, aftercare service, and education.

Patients are located by all available workers, such as public-health nurses, social workers, and physicians. During 1938 the number of cases referred by physicians showed a definite increase. Especially noteworthy was the increased number of congenital deformities referred shortly after birth, and the fact that

other types of crippling conditions were referred in the early stages rather than after extreme difficulties have occurred. Most physicians refer the cases through the public-health nurses.

During the year one new clinic center was established at Rumford. In that community are two State field nurses, a town school nurse, and two workers of the Bureau of Social Welfare and the town welfare office. All cooperate in the interests of child-health and welfare services, which of course include services for crippled children. A treatment center was established in the nurses' office where muscle training, massage, and baking could be carried out. The town furnished all the equipment.

During the year 776 new cases were seen at clinics and 1,774 clinic visits were made by approximately 1,200 individuals. Arrangements were made for a new clinic at Rockland to be held at 3-month intervals.

At the clinic the director of the Division of Services for Crippled Children takes a history of all new cases and gives a general physical examination, because the Division considers that the child should be treated as an individual rather than as a cripple. As the physical therapist, an orthopedic nurse, and a medical-social worker are present at the clinic, most clinic recommendations are either completed or well under way at one sitting.

There has been no marked change in the number of patients hospitalized or in the type of care which they have received. An increased number of patients are being treated at the Central Maine General Hospital largely because the orthopedist at the hospital attends as consultant at the Lewiston, Rumford, and Machias clinics.

Aftercare services are given by public-health nurses, social workers, physical-therapy technicians, and a medical-social worker. Among the public-health nurses are five nurses who have had some orthopedic training and are able to care for a large number of cases. Their techniques involving physical therapy have been supervised by both the orthopedic surgeon and the staff physical-therapy technician. Whenever possible, patients are treated in the physical-therapy departments of the hospitals in order to cut down the home services. Appliances are purchased by the Division of Services for Crippled Children except for those cases in which there is town or State financial responsibility and for the few cases in which the family can pay for the appliances.

During the year there was a poliomyelitis epidemic involving 137 cases. Sixty-five of these patients received home follow-up care given either by the staff physical therapist or by the five specially trained orthopedic nurses. These cases were under the medical supervision of the family doctors and one of the consultant orthopedists. A great deal of time had to be spent in the homes by nurses, but the results obtained were worth the time and effort, because 9 months after the epidemic no preventable deformities due to the disease were noted, although 75 percent of the patients were paralyzed, and a large number of these still showed weakness or paralysis.

The nutritionist of the Division of Maternal and Child Health gave 79 consultations to the Division of Services for Crippled Children, some of them at clinics and some of them after the clinic had made recommendations.

An effort is being made to increase the use of convalescent (boarding) home care in order to reduce hospitalization and at the same time have the patient available for close follow-up by the orthopedists.

Medical-social service increased in scope and value during the year. The Children's Hospital became interested in having a medical-social worker added to the staff. This worker was to come to the program in 1939 and was to be paid jointly by

the Children's Hospital and the Division of Services for Crippled Children. Community contacts have widened, and in particular there has been a more closely knit relationship between the Division of Services for Crippled Children and the Pine Tree Society for Crippled Children.

Two educational activities were inaugurated during the year. A series of talks was given before 3 county medical societies, with about 125 persons in attendance and to 5 of the 6 normal-school groups in the State, to acquaint future teachers with the program in the hope that more cases will be referred by teachers.

MARYLAND

State agency: Department of Health, Service for Crippled Children.

The development and organization of services for crippled children in Maryland had its beginning about the year 1900 under the Baltimore Council of Jewish Women. That organization found a lack of educational facilities, both academic and vocational, inadequate medical care, and lack of public support. Its work was continued until April 1927, when it proposed its own withdrawal to give way to the new State-wide organization, the Maryland League for Crippled Children.

The League immediately organized clinics throughout the State. The first was held in Allegany County in May 1927, in charge of Dr. C. E. Bennett, Professor of Orthopedic Surgery, Johns Hopkins Medical School. During the first year of the League's activities, 5 clinics were held at which 170 children were examined. The service was gradually extended, and, by 1936, 34 clinics were held with an attendance of 485 children.

When additional funds were made available by the Federal Government under the Social Security Act, the Board of State Aid and Charities was first designated as the official State agency, and the program was extended to include the services of seven physical therapists located at strategic points throughout the State, supplemented by the services of three orthopedic nurses. In 1937, by an act of the legislature, the services for crippled children were transferred to the State Department of Health.

The plans submitted to the United States Children's Bureau by the Board of State Aid and Charities and the one submitted by the State Department of Health incorporated the fundamental principles which have guided the Maryland League for Crippled Children and its professional advisers in their program. As early as 1929, legislation was passed placing the responsibility for proper classification and provision of educational and professional facilities in the State Department of Health. The joint responsibility for the care of crippled children developed close cooperation between the State Department of Health and the Maryland League for Crippled Children. Under the new plan it was natural that the official State agency and the League should continue to develop the program in cooperation.

With additional funds made available it has been possible for the official State agency to increase the number of clinics throughout the State to approximately 60 per year. Services not previously provided include the services of an orthopedic nurse and attendance of one of the physical therapists at each clinic. Through cooperation with the county health officers, it is now possible to have X-ray examinations made at all the clinics when such service is required. The interval of time between recommendation and hospitalization has been considerably shortened, and with the service of physical therapists in the communities it has also been possible to shorten the period of hospitalization to some extent.

Transportation to and from the clinic continues to be one of the most perplexing problems, as this phase of the program rests almost entirely on the volunteer services of the American Legion, civic clubs, and interested citizens. In spite of

the limitations in this type of service, however, no child recommended to clinic service has gone unattended, as the orthopedic surgeon in charge of the clinic has frequently made home visits when it was impossible for the patient to reach the general clinic.

In addition to the services of the regular orthopedic surgeons conducting the clinic, provision has been made for the services of a specialist in the care of spastic and similar conditions. Children who are examined at regular diagnostic clinics and who are found to be suffering from cerebral palsy are referred to a special diagnostic clinic conducted by this orthopedic specialist. If in his opinion there is evidence that benefit can be derived from treatment, provisions are made whenever possible for the care and treatment of the child at the Children's Rehabilitation Institute, which specializes in the care and treatment of such conditions.

With the discharge of patients from the State register because of recovery, reaching the age limit, or other reasons, it is expected that the number of children dropped from the register and new cases admitted will maintain an equal balance and assure an even flow of those admitted and those discharged.

MASSACHUSETTS

State agency: Department of Public Health, Services for Crippled Children.

The crippled children's program in Massachusetts is centered about a system of diagnostic clinics located in 10 clinic districts. A clinic is held monthly on a regularly scheduled day in a well-equipped hospital in the central city of the district. No matter where a crippled child lives, one of these monthly clinics is easily accessible.

Clinics are staffed as follows: There are 10 clinic consultants, one for each district, and each one is a recognized orthopedic surgeon. The clinic consultant is in full professional charge of all 12 clinics held in his district during a year. The State supervisor of clinics for crippled children attends each clinic and is in charge of administrative details, leaving professional matters to the orthopedist. A physical-therapy technician also attends each clinic. Depending upon the number of crippled children in a district a physical-therapy technician (there are six on the field staff) is assigned to one or to two clinics. A medical-social worker (there are four) is present at each clinic. She is responsible for the medical-social work in two or three specified clinic districts.

The clinic consultant examines and prescribes for each patient seen at the clinic. His dictated notes are transcribed to the patient's record. The physical-therapy technician notes her part of the prescription. No treatment is given at the clinic. The examinations given by the consultant are so thorough that no more than 20 or 25 patients can be taken care of during the half-day clinic session. As soon as possible after each clinic the doctor referring the case is given by letter a report of the diagnosis, findings, and prescribed treatment. He receives such a report each time his patient visits the clinic.

The aftercare given the clinic patient is vitally important; it must be complete. If physical therapy is prescribed, the physical-therapy technician either visits the patient in his home or has several patients gather in some central place for treatment, whichever is most convenient for all concerned. She gives the treatment prescribed at whatever interval is designated by the clinic consultant—semiweekly, weekly, or biweekly.

If hospitalization is recommended, the patient is at once admitted to the hospital designated by the consultant, where the latter operates. After discharge of the patient from the hospital to a convalescent home or to his own home, the physical-therapy technician begins her follow-up work. If apparatus is prescribed by the clinic consultant, the measurements he takes are given to the selected brace maker

and the apparatus is fitted to the patient by the consultant as soon as it is prepared. The important point is that once a patient is admitted to services for crippled children, he is given actual, continuous follow-up services as long as he is carried on the list of active patients; that is, until he is cured, leaves the State, or refuses to accept what is offered.

A very important feature of the program is that it has the complete support and cooperation of the medical profession. If after investigation by field workers, it is found that the case is a suitable one for admission to the clinic any child may attend, on the approval of a physician, for examination, diagnosis, and prescription, but acceptance for care rests with a designated committee of the district medical society. Of the 1,500 cases admitted to clinics so far, this approval has never been withheld. Final decision, however, rests with the State Commissioner of Public Health.

The program has progressed satisfactorily. At almost every clinic session one to three new cases are seen. This has been accomplished through the cooperation of the medical and nursing professions. Special emphasis is being placed on locating and operating on plastic cases. Operations for strabismus are also being done in increasing numbers.

MICHIGAN

State agency: Crippled Children Commission.

The Michigan Crippled Children Commission during the fiscal year 1938 hospitalized 885 more crippled children than in the preceding fiscal year. The Commission believes that this increase was due primarily to successful cooperation with other State and local agencies interested in the crippled child.

Several new county health districts were established in Michigan by the State Department of Health during 1937-38. The personnel cooperated with the Commission in locating, reporting, and following up crippled children.

During the fiscal year 3,683 court commitments for crippled children were issued, in comparison with 2,381 in the previous year. This was due in part to the necessity for issuing new orders under the new crippled children's act and in part to the fact that the cost of transporting the crippled child, since the beginning of the fiscal year 1938, has been charged to the State instead of to the county.

The Commission, in cooperation with local service clubs and medical societies, sponsored 5 diagnostic clinics during the fiscal year 1938, at which 307 crippled children were examined. Among these, 69 new cases were discovered. These diagnostic clinics have been very valuable both to the crippled child and to the State, as the orthopedic examining surgeon made recommendations regarding treatment and further care without making it necessary to transport each child to the hospital. The Commission's field nurse made a follow-up visit for each child and instructed the parents in regard to treatment and the proper procedure to follow in securing State assistance, if the family was unable to finance treatment.

The local service clubs and physicians have become more familiar with the work of the Commission. Three "refresher" courses for physicians were held during the fiscal year, each one on the evening prior to the diagnostic clinic. These courses have been helpful in bringing the local physicians and agencies in contact with the activities of the Commission.

Every effort has been made to find the crippled child early. In following this program much has been gained both for the crippled child and for the State agency.

During 1938 two additional orthopedic centers and one hospital were fully approved for the care of crippled children. Two additional orthopedic surgeons

have been approved by the Commission. This step has aided materially in early treatment and lower transportation costs for the crippled child.

The 1937 crippled children's law made provision for the crippled child needing custodial care. The Commission has taken advantage of this legislation in caring for and making possible an educational program for some of these children with the appropriation which was set aside for this purpose. The Commission hopes to continue this work.

MINNESOTA

State agency: Board of Control, Division of Services for Crippled Children. (Now State Department of Social Security, Division of Social Welfare, Bureau for Crippled Children.)

Progress has been made in the hospitalization of crippled children in private hospitals, which has helped to decrease the waiting lists of children approved for entrance to public hospitals. Attention is thus given to crippling conditions at an earlier date and the load at the public hospitals has been decreased.

An increase in the number of field clinics from 12 to 14 makes it possible for any crippled child in any rural county in Minnesota to have access to a clinic at some time during the year. There are two orthopedic surgeons at each clinic instead of one, because the number of cases at each clinic has increased to between 50 and 100 and sometimes exceeds 100. By means of the field clinics many new cases continue to be found soon after disability has occurred. Clinics are one of the most important means of finding crippled children soon after deformities have appeared.

The nursing service was of real benefit during the year and was the means of finding many new cases and rediscovering old cases in need of care. Two public-health nurses were given training in physical therapy at Harvard and will be much more valuable for the service. The field nurses have been in contact with a large number of local physicians in rural communities and have explained the program to them. Cooperation is thus established in a way which would not be possible by letter or by the usual indirect educational methods. The field nurses have embarked on a definite educational public-health campaign in the homes and in the offices of public officials and local physicians.

In regard to public-health education, the director of the Division of Services for Crippled Children, in cooperation with orthopedic surgeons, carried on several "refresher" courses for local practitioners held in conjunction with the meetings of the county medical societies. These courses have been of value to the local physicians and have been a means of explaining the services of the Division to general practitioners throughout the State.

The statistical and research aspect of the work made good progress. Several special studies were made and the results are to be published. The Division developed a new record system which will make the State register more valuable, flexible, and accessible for special studies. Approximately 1,000 new cases were added to the State register during the year. It was found that in Minnesota the ratio of crippled children on July 1, 1938, was 8 per 1,000 persons under 21. Other studies indicate that the rate in the near future will be in the neighborhood of 10.

It has been possible to increase the amount and quality of cooperation with other agencies interested in the crippled child. Cooperative facilities for investigation of cases in the counties and provisions for transportation and for additional social service have been added at the field clinics, where five or six social workers are usually needed because the cases come in so rapidly that the staff of two cannot handle the load. Cooperation with the State Board of Health and its various departments and the State Department of Education and its Division of Rehabilitation was especially noteworthy. The problem of the complete care of crippled

children is so complex that it would not be possible to give maximum care without the cooperation of every agency working with the crippled child.

MISSISSIPPI

State agency: Board for Vocational Education.

Perhaps the greatest progress made by the Mississippi crippled children's services has been in the financial field, as that has made possible the other things which have been done. In the first days of the regular 1938 session, on the recommendation of the Governor, the legislature made an emergency appropriation of \$15,000; later in the session an appropriation of \$50,000 was made for the new biennium. In view of the fact that no appropriation whatever had been made by the 1936 legislature, it is evident that strong sentiment had been created in the State in favor of the work.

Much closer cooperation was worked out with the State and county health units, and the organization of lay committees in 50 of the 82 counties of the State was a decided step forward in informing the people of the State of the work, as well as in the location and aftercare of crippled children.

The presence of two nurses on the field staff instead of one has meant a great deal in securing the consent of the parents to have children treated and in the aftercare and treatment of these children in their homes. The addition of two nurses for clinic duty at the poliomyelitis clinic which operated 1 day a week after January 1 meant much to the progress of the work as it has made it possible for the field nurses to remain in the field for the entire week.

With the help of the Mississippi State Federation of Women's Clubs, some local business men in the city of Jackson, and one of the Jackson daily papers, funds were raised for the purchase of two "iron lungs." Because of the association of the editor of the paper with the work of the crippled children's services, much publicity has been given to the program through his paper and associated papers throughout the State.

Before there was a State appropriation the greatest problems were naturally financial. Money had to be raised through donations from individuals and organizations, not only for the regular program but for a poliomyelitis epidemic that has lasted more than 2 years. As soon as the individuals or organizations were informed of the need, these problems were for the most part quickly solved.

The program in Mississippi has expanded so rapidly that the greatest problem at the end of the fiscal year was hospital space. The orthopedic surgeons, the pediatrician, and consultants work together harmoniously and have the program very much at heart. The hospitals cooperate to the limit of their capacity. The problem of trained personnel is being met as rapidly as possible by having the nurses go away for specialized training. The program is already outgrowing financial bounds, so that once again the major problem is that of finance.

MISSOURI

State agency: University of Missouri, State Crippled Children's Services.

In summarizing the activities and progress of the State Crippled Children's Service in the fiscal year 1938 it can be stated briefly that the major change was in perfecting the organization of the field nursing services. Until Federal funds became available there was no field nursing service and only one central hospital service.

During the year the State was divided into five districts, and a specially trained orthopedic field nurse was placed in charge of each district. This service in general takes care of the rural areas in each district and omits the counties and areas immediately surrounding large cities.

Three additional hospital centers were provided where hospitalization is carried out under the direction and supervision of a properly qualified orthopedic surgeon. With four hospital centers available, the transportation of children to hospital centers for treatment has been materially improved, children going in general to the closest center.

Convalescent care is supplied at one convalescent home only; the facilities of this home were increased somewhat through the additional funds available.

There has been an increased spirit of cooperation during the year between the State Crippled Children's Service and other agencies working with crippled children. Specifically, public-health units are being established, each of which has been very cooperative in looking after cases in its particular counties and in arranging for clinics, transportation, and the like.

The State Vocational Rehabilitation Service sends a representative to each of the diagnostic clinics, so that patients examined at the clinic are referred directly to that department when appropriate, and such investigation as is necessary is made by its own representatives. Other patients referred to the rehabilitation service by letter were visited promptly, and some attempt was made to plan a joint program.

The major private organization interested in crippled children's work, the Missouri Society for Crippled Children, was helpful in arranging for care for children and adults over the State age limit, thus permitting continued care of patients who otherwise would not receive it because of age restrictions.

MONTANA

State agency: Department of Public Welfare, Services for Crippled Children (now Division of Crippled Children).

In 1937 the State Legislature abolished the State Orthopedic Commission and transferred its responsibilities to the newly created State Department of Public Welfare. The appropriation for crippled children's services was increased to \$30,000.

On July 1, 1937, Services for Crippled Children became a functioning division of the Department of Public Welfare. The legislative act (Session Laws of 1937, ch. 82) created in every county seat a county department of public welfare. These departments were made the responsible agencies for the administration of the State program. With the creation of the State Department of Public Welfare and the county departments of public welfare, minimum qualifications for personnel were established (known as the merit system). These minimum qualifications apply to all State and county personnel. Salary schedules also were established. Personnel qualifications in Services for Crippled Children are based on qualification standards established by the national organizations in the respective fields and recommended by the United States Children's Bureau Advisory Committee on Services for Crippled Children.

The State Department of Public Welfare appointed a technical advisory committee. It also limited the orthopedic surgeons on the staff to those certified or eligible for certification by the American Board of Orthopedic Surgery.

On July 1, 1937, there was only one registered physical therapist in Montana. Two registered physical therapists have since been appointed, and a third is eligible for registration.

NEBRASKA

State agency: Board of Control, Child Welfare Division.

Much was accomplished indirectly as well as directly in the development of the crippled children's program during the fiscal year 1938. The State-county organization for case finding and investigation of economic need was greatly

improved. The program of the State Orthopedic Hospital, which formerly functioned as a combination hospital and convalescent institution, was considerably strengthened. Convalescent homes were established outside the hospital, the latter now being used only for hospital cases. The medical staff was expanded to include two additional orthopedic surgeons as well as a pediatrician and a pathologist. Laboratory and other facilities were greatly expanded. Medical records were improved. A registered physical-therapy technician was added to the staff. A medical-social-work department was established, social records were kept for the first time, and a systematic follow-up program was inaugurated. The out-patient service, which was formerly conducted only one morning a week for all cases, was changed to provide for two orthopedic clinics and one pediatric clinic a week. Medical staff meetings were initiated. The hospital was approved by the American College of Surgeons during the year. Consultation service to local physicians on orthopedic cases was also initiated.

The progress in carrying out the provisions of the State plan for crippled children was more marked in the first 2 years of the program than in 1938, when progress consisted chiefly of improvement in administrative techniques and strengthening of relationships with professional groups and with the county departments.

Among the indirect results of the crippled children's program during the year was a very marked increase in the interest shown by the medical profession and the public generally in methods of meeting the problems presented by the physically handicapped child whose parents are financially unable to provide for him. The medical profession generally accepted the program during the year and thinks of it as an experiment in the area of medical care for the needy. The program developed significant administrative techniques in this area, including standards of care, personnel qualifications, eligibility, administrative organization, State-county relationships, payment for professional services, and cooperation and coordination with medical, health, nursing, and welfare groups. Through the work with crippled children the public and professional groups were made more aware of the need for adequate medical and social service for children suffering from nonorthopedic conditions. Interest has developed in meeting the special need for training of children, with cerebral birth palsy, as well as in providing educational opportunity for the home-bound child.

The cooperation of county welfare departments with the local medical societies on crippled children's cases has stimulated the development of local programs of medical care. Local physicians without adequate facilities for medical investigation and specialized treatment are looking to the State service for consultation, medical service, and leadership in treatment for other than orthopedic conditions. The social, psychiatric, and psychological study of children in need of these services under the crippled children's program has demonstrated the value of these specialized services for children suffering from nonorthopedic conditions.

NEVADA

State agency: Board of Health, Maternal and Child Health Division. (Now Department of Health, Division of Maternal and Child Health and Crippled Children's Services.)

Nevada began operation of the crippled children's program for the first time in the fiscal year 1938.

The first step was to make a State-wide survey to locate handicapped children and classify them, separating those that might come under the crippled children's program. About 300 children were located. The first half of the year was taken for this part of the work.

Itinerant diagnostic clinics were held in five centers chosen for their convenience to the greatest number of children. Ninety-seven children attended these clinics held by an orthopedic surgeon of Los Angeles, Calif. Seven patients were suffering from other crippling conditions such as harelip, cleft palate, and deafness. Of the remaining 90 children the surgeon's report shows that—

26 children are ready for hospitalization.

5 children will need surgical care in years to come.

8 children need orthopedic direction and consultant care of pediatricists, neurologists, and so forth.

14 children need no active treatment at present.

23 children would benefit from orthopedic nursing and physical therapy.

7 children cannot be benefited by medical or surgical care, but vocational training might fit them to be self-sustaining.

7 children are hopelessly handicapped.

Some of the children needing care have been able through their own resources or through other means to get the necessary treatment.

Two children have been fitted with braces and one was hospitalized. More than this could not be done with the funds available.

NEW HAMPSHIRE

State agency: Board of Health, Division of Maternal and Child Health and Crippled Children's Services.

Progress in crippled children's services in this State was made chiefly through contacts of the nurse-physiotherapist. Case finding was made possible through direct and indirect contact with known cases; birth palsies were picked up at the time of birth or soon after through contacts with known cases in home visits by nurses. Private physicians cooperated by reporting all known crippling conditions early, and public and private agencies also cooperated in case finding.

Much more orthopedic and plastic surgery was done in 1938 than formerly, especially in cases of cleft palate and harelip.

More cases were admitted to hospitals than in former years. A neurologist who took interest in the cases gave volunteer service.

The work in clinics was expanded through more complete follow-up work. This was made possible chiefly by cooperation with district nursing agencies, private agencies, and public-welfare agencies.

Nursing service for crippled children was expanded, all State nurses doing follow-up work and giving care in their own districts.

During the year two nurses were given stipends for a special 7 weeks' course in physical therapy, so that follow-up treatment may be of better quality.

Physical therapy was extended into the home and into the hospital clinics, thereby reaching more of the patients and increasing the amount of surgical treatment.

NEW JERSEY

State agency: Crippled Children's Commission.

One of the major features of the program of the Crippled Children's Commission which showed marked progress during the fiscal year 1938 was the locating of crippled children. As part of the survey of nursing and health organizations of the State, the Commission's nurses stressed the importance of locating and reporting all crippled children. Active cooperation was enlisted from all the organizations with which contact was established, with the result that 2 months after the completion of the survey the total number of monthly referrals of crippled children

had increased approximately 17 percent and the number of individual agencies reporting these children had increased approximately 28 percent.

In the spring of 1938 the Commission wrote an article entitled "How the School Nurse Can Cooperate with the Crippled Children's Commission," which was published in the *School Nurses' Bulletin*. This article stressed the importance of reporting all crippled children located by the school nurses, with the result that a number of cases have been referred to the Commission by these nurses.

Another step in progress was the addition of 6 hospitals to the 38 used by the Commission for the care of crippled children. These 6 hospitals are located in the heavily populated counties—2 in Essex, 2 in Passaic, and 1 each in Hudson and Camden. The Commission finds that with the added facilities made available by the use of these hospitals there are no waiting lists of crippled children in need of hospitalization or clinic care in the State of New Jersey.

The procedure inaugurated by the Commission in connection with all new poliomyelitis cases is worthy of note. It is mandatory in New Jersey for physicians to report all new poliomyelitis cases to the State Department of Health. This department forwards a copy of these reports to the Commission. Immediately upon receipt of such a report a letter is written to the physician, who is offered the aid of the Commission in the purchase of appliances and in the provision of hospitalization and necessary convalescent care. At stated intervals follow-up calls are made by the Commission's nurses to insure that every child is receiving proper care and attention, with the result that every poliomyelitis case reported to the Commission during the fiscal year received or is now receiving the care necessary for physical rehabilitation.

In connection with the aftercare of such cases the Commission sponsored the erection of a new therapeutic pool and the purchase of modern physical-therapy equipment at the Betty Bacharach Home in Atlantic City, thus making available to the poliomyelitis victims of New Jersey the most modern methods of aftercare, second only to Warm Springs, Georgia.

The use of the discharge report by the hospitals, on which is recorded the date the child is to return for re-examination or clinic treatment and the type of after-care service prescribed by the orthopedic surgeon, have enabled the Commission to set up a definite procedure for follow-up or aftercare treatments.

The progress made by the cerebral-palsy experimental unit at Babbitt Hospital is noteworthy. During the fiscal year the number of boys at the hospital increased from 10 at the beginning of the year to the full quota of 21. Without exception every child at the hospital responded to treatment. This is shown in improved muscular coordination and is reflected in increased social confidence.

During the year Dr. Phelps wrote an article on cerebral palsy and later addressed the Academy of Medicine of Northern New Jersey on "Cerebral Palsy and Poliomyelitis as They Concern the Family Doctor, the Orthopedist, and the Neurologist." These papers were printed in the journal of the Medical Society of New Jersey and reprinted in pamphlet form. Both pamphlets were mailed to physicians throughout the State. The letter of transmittal to the physicians urged that they report to the Commission all cases of cerebral palsy with which they come in contact. The results are indicated by the fact that at the monthly cerebral-palsy clinics almost twice as many children per clinic were being examined at the end of the fiscal year as at the beginning of the year. As of June 30 1938, 227 children had been examined in these clinics. The data collected indicate that in New Jersey cerebral palsy is one of the most serious forms of crippling in respect both to the number of children affected and to the severity of the handicaps resulting from it.

NEW MEXICO

State agency: Department of Public Welfare, Division of Crippled Children's Services.

During the fiscal year limited progress was made in carrying out the State crippled children's plan. There was further development of case location through the health department, schools, civic clubs, local county committees, and local welfare offices.

The Division of Crippled Children's Services worked out with the Carrie Tingley Hospital, which was completed during the year, a cooperative plan whereby the Division took responsibility for the admission and discharge of all patients other than private. This plan made it possible to hospitalize a large number of children and greatly increased the responsibilities of the Division.

Itinerant clinics were practically abandoned during the year, as weekly clinics at Carrie Tingley Hospital took their place. However, at the end of the year a plan was made whereby the Division of Crippled Children's Services and the Carrie Tingley Hospital staff were to conduct a monthly clinic in each of four clinic districts throughout the State. This made it possible to give more services to children in communities near their own homes. This plan also revived the interest of local communities by bringing the program back to them.

There was no development of foster or convalescent homes. The only foster homes used in the State were those utilized for overnight stops for children en route to and from the hospital. A convalescent home was maintained for a few months in connection with an out-patient service which the State Department of Public Welfare sponsored in Hot Springs, where Carrie Tingley Hospital is located. Children were retained in the convalescent home for physical therapy, to await braces, and when other situations warranted such care. The service did not seem practical, and consequently the out-patient service and the convalescent home were discontinued at the end of the fiscal year.

There was little development in aftercare services, as more emphasis was placed upon preparing children for treatment rather than upon the necessary aftercare program. A cooperative plan with the State Department of Public Health was fostered whereby the public-health nurses gave as much aftercare as possible to children upon discharge from the hospital.

The need for a technical advisory committee is recognized, but such a committee has not yet been organized. The State advisory committee on crippled children's services did not function as a group during the year, but the Division was quite consistently in touch with individual members.

NEW YORK

State agency: Department of Health, Division of Orthopedics.

The program for the rehabilitation of crippled children in New York State has been in force since the epidemic of 1916. Since that time certain procedures have grown up and policies have been established.

The program includes: (1) Diagnosis at State clinics, permanent or itinerant, by orthopedic surgeons on the State staff; (2) hospitalization at the New York State Reconstruction Home at West Haverstraw and at more than 50 hospitals located in various parts of the State; (3) aftercare in convalescent homes or in the child's own home; and (4) a corps of State orthopedic public-health nurses in districts who arrange for clinics and for the care recommended by the surgeon after diagnosis, at the time of discharge from the hospital or convalescent home, and during the period after the child's return to his own home.

Funds for this work have been provided since 1927 by the legislature and local fiscal authorities. Federal funds have been used to supplement the State

program in providing additional nurses and additional office staff for routine clerical work.

The only new services undertaken with Federal funds have been those of a statistician and a medical-social worker added to the staff. The statistical work has been most useful in bringing to light interesting facts and figures from the mass of data gathered since 1916. It is hoped that it will soon be possible to make deductions from the statistical data that may have a bearing upon the direction of the work.

The addition of a medical-social worker to the staff has been of value in making possible a better tie-in with the various social groups and organizations throughout the State doing related work. She has served to interpret to the nursing field staff many of the social problems resulting from handicap which affect the patient's ability to profit from medical care.

The great need for a worthwhile plan of education of the general public in matters relating to handicapped children is generally recognized. Early discovery has been one of the great problems. A program to acquaint the general public with the details of this phase alone of the handicapped children's program would be an immense piece of work in itself in view of the size and population of New York State. A series of lectures and demonstrations has been developed to acquaint the nursing groups with early signs and symptoms of these conditions. This, however, is only a beginning; if worthwhile results are to be obtained a regular program must be established as part of the general education of those who are in closest contact with the younger element of the population.

There is need also of a program to afford some aid to the large number of children suffering from cerebral palsy that have already been located.

NORTH CAROLINA

State agency: Board of Health, Division for Crippled Children.

The North Carolina State Board of Health has completed the second year's experience in the direction of a coordinated plan of services for crippled children. The State agency believes that this period has demonstrated again the wisdom of the original features of the plan and is gratified at the record of achievement—a marked advance in contrast to periods preceding the enactment of the Federal Social Security Act with its provision for grants-in-aid to the States for extending and improving services for crippled children.

The essential features of the plan provide the following services: (1) Location of crippled children and registration of those eligible for classification under the definition provided in the plan; (2) specialized diagnostic services; (3) specialized treatment and care; (4) field supervisory and follow-up services; (5) engendering and coordination of activities of public local agencies and lay organizations in endeavors for crippled children; and (6) engendering of general interest and education of the public in the needs of crippled children.

The registration of crippled children showed considerable progress in the fiscal year 1938. It will require time, however, to collect the minimum information essential to the standards suggested for registration. On every hand interest and cooperation have been manifested in referrals by both public and private groups. Clinic records indicate that approximately 23 percent of admissions for the year have been new cases. The register includes approximately 13,000 of an estimated 20,000 eligibles.

The State clinics, numbering 18, were conducted at strategic geographic points monthly or more frequently if such a need was indicated by attendance. These provide facilities and services of specialized personnel for expert diagnosis, classification, and treatment. There were 9,782 admissions to these clinics within the

period, an average monthly admission for each clinic of 45 children. The length of the sessions ranged from a half day to a full day, as attendance indicated from time to time. The reported treatment procedures in the clinics were as follows: 1,341 dressings, 692 casts, 398 corrective shoes, 314 exercises, 199 braces, 146 diets, 102 massages, and 84 proprietary bandages. These reports were not complete. Hospital care was arranged for 1,606 children.

Seventeen selected general hospitals gave care to 1,044 children, representing approximately 65 percent of the hospital load. The remaining 35 percent, or 562 children, received care at the State Orthopedic Hospital. These admissions represent 80,255 bed days of care.

No convalescent care was furnished by the State agency in institutions as such, although some of the care given at the State hospital might not have been necessary had there been provision for convalescent care. This is also true in a more limited way of the general hospitals.

The State has only recently undertaken care of crippled children in boarding homes. Insufficient time has elapsed since this type of care was begun to make an evaluation. Suffice it to say that such a plan appears feasible for a State with a widely scattered rural population.

The activities of the field staff have been of unusual value in developing the whole plan of services, in coordinating local services, and in engendering increased interest on the part of local groups. These activities are reflected in the following figures: Children admitted to field services, 3,122; field and office visits, 6,383; conferences with surgeons, 288; conferences with health officials, 447; conferences with welfare officials, 477; other individual conferences, 858.

The activities of the State staff in specific educational discussions included 3 radio addresses over 5 local broadcasting systems and 29 other talks and addresses to audiences totaling 1,471.

NORTH DAKOTA

State agency: Public Welfare Board, Division of Child Welfare.

The allocation of Federal funds to North Dakota for services to crippled children in November 1936 made possible for the first time the development of State services for the physical restoration and social readjustment of physically handicapped children. The Public Welfare Board of North Dakota established a Division of Child Welfare to administer child-welfare services and crippled children's services, and, with the agreement of the Board of Administration, the powers delegated to it by child-welfare laws of 1923. This administrative structure has resulted in an integration of crippled children's services with county and State welfare, public-assistance, and social-welfare programs. Through the coordinated field staff supervising all public-assistance and welfare programs administered by the county welfare boards improvement has been made in local case-work services for crippled children and in the interpretation of policies adopted by the State agency in administering services to crippled children.

The administrative procedures established and activities planned in the fiscal year 1937 were followed with slight modifications during the next year. Realizing that the annual budget of \$23,556 for 1937 was insufficient to meet the medical and social needs of the crippled children eligible for services, the Public Welfare Board allocated \$50,000 for 1938 to match the Federal funds for services for crippled children. These additional funds made it possible to extend treatment and medical care to 633 children, as compared with 116 children receiving medical treatment during the fiscal year 1937.

The maximum age limit for assistance to crippled children was changed from 18 to 21 years. Congenital strabismus needing surgery for correction was added to the types of crippling conditions to be accepted for medical treatment.

A total of 1,077 physically handicapped children were examined at the 11 itinerant diagnostic clinics conducted during the year. Two of these clinics were entirely new public services in their areas; in 9 centers similar clinics had been held the preceding year. The attendance at these clinics showed that the public had a better understanding of the purpose of these diagnostic clinics, as fewer children attended whose physical defects were nonorthopedic. Because of the smaller attendance the orthopedic surgeons and physical-therapy technicians were able to spend more time with each patient and to explain to parents, nurses, and social workers follow-up care and services. A representative from an artificial-appliance company was present at all clinics to take measurements for braces and to check the performance of appliances purchased by the State agency during the year.

Local case-work services were increased for locating and giving follow-up services to crippled children. Public-health-nursing services for crippled children and for the teaching of mothers to give treatments and convalescent care recommended by physicians were also increased during the year.

During August 1937 and June 1938 the North Dakota Anti-Tuberculosis Association cooperated with the Division of Child Welfare at Camp Grassick, the Association's 12-year-old health-education project, stressing value of rest, food, and health-habit training, plus balanced activity and a general rehabilitation program for children of low vitality who were free from communicable disease. Camp Grassick enlarged its physical-education program to include physical-therapy and additional occupational-therapy services under the supervision of the orthopedic surgeons. A physical therapist was provided throughout the season by the Public Welfare Board. A physical-therapy department made available treatment tables, a whirlpool bath, sun lamps, large mirrors, games, and exercise apparatus. Parents of crippled children attending were urged to visit the camp frequently to be instructed in the treatments and exercises which should be carried on with each child in the home. Explicit instructions for treatments to be carried on at home were written out for each child by the physical therapist for the use of parents, public-health nurses, child-welfare workers, and social workers in directing the child in the physical therapy necessary in his physical restoration. In a rural State, where the traveling expenses of a physical therapist would be exorbitant, the facilities of Camp Grassick have made it possible to have a center where physical-therapy services could be extended to crippled children.

A number of children whose cleft palates had been repaired and who had speech impediments were given speech training as part of their postoperative treatment.

Arrangements were completed in the latter part of June for a medical-social consultant on the State staff beginning July 1938.

OHIO

State agency: Department of Public Welfare, Division of Public Assistance, Bureau of Charities, Crippled Children's Bureau. (Now Department of Public Welfare, Division of Public Assistance, Services for Crippled Children.)

During the fiscal year 1938 effort was centered on finding the crippled child, giving much attention to the school enumeration. Though this is still not satisfactory, a large number of children have been placed under treatment who were located through this means. Other children were located through birth certificates. Families and private physicians are becoming more interested in reporting crippled children.

In each of the counties the social workers in the programs for aid to dependent children and child-welfare services and in the juvenile court were very helpful in keeping the State agency informed of crippled children under their care. A majority of the children, however, were reported through the diagnostic clinics.

These clinics are organized by the State orthopedic nurses in connection with or in cooperation with the local health departments and agencies interested in children's work. The State Department of Health and the State Department of Education, as well as the Ohio Society for Crippled Children, are represented at these clinics. Furthermore, a special invitation is extended to all physicians in the community. The permanent clinics have been sending in reports on all children examined, and the number of children has increased. It is interesting to note that this department took care of a greater number of crippled children in 1938 than ever before.

The institutes for the public-health nurses conducted by the State Department of Health have been most beneficial. Nurses from several counties are usually invited to these institutes and a representative of this department attends. Conferences with the State orthopedic nurses are held at each meeting.

The institutes conducted by the Division of Public Assistance were attended by a representative from the Crippled Children's Bureau, and crippled children's work has been stressed. These institutes cover several counties.

Owing to the installation of new equipment in several of the hospitals more specialized and modern treatment can be given. There were decided improvements in several of the convalescent homes within the year, and a new convalescent home was dedicated.

A physical therapist was placed in each of the special schools for crippled children throughout the State, and new equipment was installed for the physical-therapy department in several of the schools.

Of the 45 orthopedic surgeons on the State agency's approved list, 37 have been certified by the American Board of Orthopedic Surgery. All hospitals are approved by the American Medical Association or by the American College of Surgeons.

A greater number than formerly of older children are being rehabilitated under the supervision of the rehabilitation bureau.

There are undoubtedly crippled children who have never been reported to any agency, but more and more children are being reported and are under treatment. Children from all 88 counties in the State are under treatment.

OKLAHOMA

State agency: Commission for Crippled Children.

Someone has said that the function of education is to teach the individual to do better than which he would do anyway. The Oklahoma program for the care of crippled children did not have many innovations or changes during the fiscal year 1938, but there were many distinct improvements in the various phases of the work. Possibly we are becoming educated in that we are doing better the things we have been doing for several years.

The number of diagnostic clinics held showed no increase over the previous year but the follow-up was far more definite and fewer cases were lost. More and more the diagnostic clinics are becoming check-up clinics rather than discovery clinics. It is felt that the diagnostic clinics are valuable and will always remain so in arousing and sustaining public interest.

The foster-home or boarding-home program was expanded and perfected. Definite standards were established. Distinction has been made among types of homes and types of cases. The fact that a major part of the orthopedic and

plastic work is done in Oklahoma City gives opportunity for an almost unlimited development of the boarding-home program, if finances become available.

The establishment of a closer working relationship between the social-service department of the Oklahoma Hospital for Crippled Children and the field nurses has done much to avoid unnecessary trips and confusion. Arrangements have been made so that a copy of each letter written by the medical-social worker in respect to a patient goes directly to the field nurse of the district. These letters are of special help with the patients living long distances from the hospital.

There is always a tendency for any hospital to serve its immediate locality or neighborhood most intensively. The development of flexible arrangements for transportation has done much to remove the distance handicap, however. Bus companies and railroads advance transportation on order by the judge or the hospital. The charge for transportation at a rate of 1 cent per mile is filed against the respective county or commission. Thus there is seldom a legitimate excuse for the patient's not returning to the hospital or out-patient department when directed to do so.

The working relationships with the public-health units and with the welfare directors, especially the child-welfare directors, have improved through understanding and through working together.

During the year Oklahoma experienced one of the worst epidemics of acute poliomyelitis in its history. The greatest incidence of the disease occurred in the south central section of the State, where in some counties the incidence exceeded 40 per 100,000 population. The case rate for the entire State during the calendar year 1937 was 18.1 per 100,000 population. During the first 6 months of the fiscal year 1938, there were more than 300 cases of poliomyelitis on the Commission's active follow-up list. These children were seen at monthly itinerant and permanent clinics by orthopedists who made recommendations regarding their needs for further medical and nursing supervision, foster-home care, appliances, and so forth.

OREGON

State agency: State Relief Committee, Crippled Children's Division. (Now State Public Welfare Commission, Services for Crippled Children.)

The Oregon crippled children's program as provided by State and Federal law began active operation January 20, 1938, under the Crippled Children's Division of the State Relief Committee of Oregon. In the past the State of Oregon was served only by the Shriners' Hospital, which cared for cripples up to 14 years of age. Individuals above this age limit were occasionally cared for through unorganized efforts.

The Oregon crippled children's program labored in its first months of existence to inform those interested in crippled children's services of the objectives of the State program.

Four hospitals and seven orthopedic surgeons were selected to provide service under the program.

Three public-health nurses were employed, one of whom had completed advanced orthopedic-nursing training before affiliation with the office, one of whom obtained training during the fiscal year, and one for whom such training was planned for in 1939. A physician with orthopedic training was employed as assistant director.

The Oregon State register of crippled children was established and 218 children were enrolled. The names of approximately 500 crippled children were referred by the State Board of Health as candidates for benefits of the program.

During the 5½ months of operation of the program 6 itinerant field diagnostic clinics were conducted. In these clinics approximately 225 crippled children

were examined by orthopedic surgeons. The surgeon's recommendations were referred to the physician sending the child to the clinic. All children financially unable to meet the expense of the treatment recommended were declared eligible for care at the expense of the Crippled Children's Division of the State Relief Committee. Individual family-budget studies were made by social workers of the county relief committees, who at the same time determined the child's social need.

Oral agreements with the Vocational Rehabilitation Service, Child Guidance Clinic, State Board of Health, State Department of Education, and the Shriners' Hospital were established as preliminary moves to written understandings.

A technical medical advisory committee was formed to assist the medical director. This committee had three meetings.

Hospitalization of orthopedic cripples was started on a small scale during the last 2 months of the fiscal year.

Preliminary arrangements were made for care during 1939 of cleft-palate, harelip, and burn-contracture cases.

Finally, the procedures and general ground work of a foster-home service adjacent to the treatment center were formulated.

PENNSYLVANIA

State agency: Department of Health, Crippled Children's Service.

The following is a summary of the plan which has been carried out for crippled children during the fiscal year 1938.

The Commonwealth of Pennsylvania was divided into 13 districts, each district comprising 3 or more counties, depending on the population. Each district was placed in charge of a competent and qualified orthopedic surgeon, who was accredited or eligible to be accredited by the American Board of Orthopedic Surgery. Surgeons were also chosen by virtue of their connection with a university or a medical college, or by their reputation as being outstanding in their specialty.

Each surgeon was paid on a part-time salary basis for holding four clinics during the fiscal year in his assigned territory and for doing the necessary operative work upon the crippled children examined at the diagnostic clinic.

Hospitals used by the individual surgeons were selected by the surgeons themselves with the restriction that the hospitals used for State cases must be approved by the American College of Surgeons.

Appliances recommended by the surgeons for deforming conditions diagnosed in their clinics were paid for by the Department at a fair rate as billed by each individual brace maker. Plaster-of-paris casts and X-rays prescribed at the time of the clinic for a patient for whom hospitalization is unnecessary were paid for by the Department at the regular charge for such services. Physical-therapy treatments or medications necessary for improving the orthopedic condition of patients were also paid for at the prevailing rate.

All long-term patients are referred to the State Hospital for Crippled Children at Elizabethtown.

The program for convalescent and foster-home care is directed by a qualified medical-social worker who places children following the termination of their operative or physical correction in a convalescent or foster home, provided such care is considered beneficial or necessary for the patient. The medical-social worker investigates all patients recommended for such care by the surgeon and maintains at all times an efficient investigation and check-up of convalescent and foster homes used in the care of these patients. The Department does not

stop at the physical correction of the patient but attempts to bring about a social readjustment as well.

In many instances children who were over the age limit for care under the program and who were eligible were referred for rehabilitation to the Bureau of Rehabilitation in the Department of Labor and Industry.

The problem of care of those patients over 16 years of age deserves consideration. Exceptions have been made in the past, and patients have been cared for by the Department up to the age of 21 years, when it was felt that operative work or appliances would be of great benefit in enabling them to make a livelihood and when it was known definitely that the patient was otherwise unable to secure this treatment.

RHODE ISLAND

State agency: Department of Public Health, Crippled Children's Division.

During the fiscal year 1938 approximately 161 children under the age of 21 were either located by or referred to the Crippled Children's Division, making a total of 1,668 crippled children on the register. They were immediately investigated by the Division's medical-social worker to determine their eligibility with reference to mental condition and economic status. Those meeting the requirements established by the State agency were accepted for care.

Forty-five diagnostic clinics were held, at which 307 children were examined and recommended for treatment. One hundred and seventy-five were hospitalized for operative treatment and 64 were furnished with surgical shoes, braces, lifts, supports, splints, crutches, or the like. Other children were recommended for pool treatments and physical-therapy treatments in hospital clinics and at their homes. It was possible for the Division to take its own X-ray photographs through use of the facilities of the Division of Industrial Hygiene of the State Department of Public Health.

When necessary, consultation services were rendered by pediatricians and neurologists. From October to June 4, classes a week were held at the Providence Boys' Club pools and 2 classes a week at the Pawtucket Boys' Club pool. At these classes, each of which had an average attendance of 15 children, water treatment and physical-therapy treatment were administered by the Division's physical-therapy technicians.

During the summer months a camp for crippled children was conducted at Lakeside under the supervision of the Crippled Children's Division. A total of 110 children enjoyed fresh air, sunshine, and good food. Water treatment and massage were given 6 days a week by the physical therapists. Weather permitting, the children went in bathing every day, 2 life guards being in charge while the children were in the water.

Seventeen children, 16 years of age and over, were referred to the Division of Rehabilitation of the Department of Education and the Bureau for the Handicapped.

SOUTH CAROLINA

State agency: Board of Health, Division of Crippled Children.

The major objectives of the program for crippled children in South Carolina are as follows:

1. Opportunity for care should be equally available to crippled children of rural and urban areas, without regard to race.
2. All efforts in behalf of crippled children should be directed primarily toward the prevention, correction, or minimizing of disability.
3. Children with physical disabilities should be given the opportunity to obtain, as far as possible, an uninterrupted and adequate education.

The services of five recognized orthopedic surgeons were secured to hold weekly clinics in the five orthopedic districts. Adequate assistance in the way of interns and trained nurses is given in each district, and thus a more satisfactory clinic program has been developed.

The American Legion is responsible for transporting all children of veterans to clinics and to hospitals.

Cases are being reported with much more adequate information during this year by the county school-attendance teachers. Therefore, many more rural crippled children are being reached and helped.

The foster homes have filled an important gap in the program. Children in these homes are provided an opportunity not only for physical improvement, but also for training in personal hygiene, for happier and more sanitary home living, and for a certain amount of academic education. The cost of this care is \$1.50 per child per day.

Many crippled children who are found to be suffering also from malnutrition are sent to the foster homes. Some must go before an operation so that they may be able to respond better to the treatment.

The average gain in weight per child in foster homes in the past 3 months has been about 7 pounds. A pediatrician, member of the technical advisory committee, has prepared lists of diets which the foster mothers have used in feeding the children of different ages in their homes. He has also offered further assistance in special cases.

An orthopedic consultant nurse is receiving training in orthopedic nursing at Boston, and will instruct the county nurses in the proper follow-up care of crippled children in their homes.

The local groups have made it possible to avoid neglect of any phase of the program by providing needed clothing in some cases; educational toys, books, special teaching service, and the like for others; hot lunches for crippled children at schools and clinics; rolling chairs; tricycles; and for one child a typewriter for use in exercising her fingers.

A marked improvement may be seen in reporting crippled children to the State agency; in having clinics better organized (certain counties have a designated number of crippled children attend diagnostic or operative clinics weekly, thus maintaining clinics more nearly uniform in size); in having regular and well-publicized dates for holding diagnostic clinics; in securing proper and more nearly adequate cooperation from lay groups; in providing the majority of the patients with the advantages of public-school education (the latter problem has been handled by local lay groups and individuals); and in seeing that families of these handicapped children have access to welfare workers who may help with their social problems.

The Rotary Club, Kiwanis Club, the Masons, Federated Clubs, parent-teacher associations, and some of the county societies for crippled children rendered valuable assistance in carrying on aid to the crippled children in their homes and in transporting crippled children to school in some sections of the State.

The State Highway Department and the State Department of Education cooperated in a prevention program by placing the book "Man and the Motor Car" in the high schools of the State and urging the organization of school safety patrols in all elementary and high schools. The State Congress of Parents and Teachers further cooperated by offering prizes to high schools and elementary schools for the best essays submitted on this book and for the best posters portraying the schoolboy patrol.

The State Division of Crippled Children believes that with an intensive study of the subject of highway, home, and farm accidents on the part of the young boys

and girls, the number of accidents will be greatly lessened and many of the worst deformities will ultimately be prevented.

The annual report shows 2,319 cases of children reported to the Division since February 1935 and diagnosed by the orthopedic surgeons as having conditions in need of correction.

Reports from other sources show that in addition to this number there are 4,312 crippled children in South Carolina who are private cases and 1,500 crippled children who are Shrine cases. The known cases in the State thus total 8,131.

A State register including the name of every crippled child in the State whose condition has been so diagnosed by a licensed physician and who has been reported to the Division is now being kept in the office of the Division.

SOUTH DAKOTA

State agency: Board of Health, Division of Crippled Children.

The Division of Crippled Children concerns itself with locating crippled children and investigating them so that their eligibility may be established. The investigations are carried on by field nurses, child-welfare workers, and in certain instances by public-health officials in various county or district units. When eligibility has been established, crippled children are entitled to attend diagnostic clinics held at several points within the State. Clinical reports and requests for service are made by the orthopedic surgeon at that time. Children are then hospitalized when the hospital case loads are such that more patients may be cared for. Follow-up service is provided by nurses acting under the orthopedist's direction and is rendered either in field clinics or, in an emergency, at the hospital center.

Agreements were made during the fiscal year 1938 whereby the Division of Crippled Children received the cooperative aid of the social workers employed by the Department of Social Security, Division of Child Welfare. The two hospital centers within the State developed plans whereby qualified physical therapists could be added to their staffs. Limited hospital and surgical authorizations were made, thus creating better estimates of obligated funds. An organized system of clinics throughout the State rendered service to both old and new cases and served as an adequate method of eliminating cases outside the scope of the program, which formerly required transportation and services incidental to visits at hospital centers.

TENNESSEE

State agency: Department of Public Health, Services for Crippled Children.

There have been many ups and downs in the administration of the crippled children's program since July 1, 1937. New policies have been inaugurated, new forms adopted, and, in fact, a new program has been set up which is being integrated as rapidly as possible with the program of the Department of Public Health.

For 3 months after July 1, 1937, only emergency cases were accepted and the collection of delinquent county accounts was emphasized.

Because of time spent in the formation, adoption, and inauguration of the new program, the actual number of crippled children handled during the fiscal year 1938 was not so large as that for the preceding fiscal year.

During the year two lay field representatives were replaced by regional nurses. One of these had experience and training in orthopedic nursing, and the other had a special course in orthopedic nursing and was to return to the field October 1, 1938.

Clinics—monthly and itinerant—were in operation at the end of the year, and the State agency is looking forward to better days.

TEXAS

State agency: Department of Education, Crippled Children's Division.

The progress made by the official State agency during the fiscal year 1938 might be summarized as follows: A form was adopted which, when adequately filled out, will give a social history of the crippled child. The standards of hospitals used by the State agency were raised; only those approved by the American College of Surgeons in the State will be used. A technical advisory board was appointed. Members of this board will be called in for consultation upon many of the technical problems confronting the director of the State agency. The Tom Hughes Crippled Children's School of Port Arthur was established. At the suggestion of the director of the State agency, the maximum age of crippled children admitted to the State Hospital in Galveston was raised from 12 to 14 years in October of 1937, the year the State register was started. A plan for selecting, licensing, and supervising foster homes was made with the Division of Child Welfare, and, finally, a most satisfactory cooperative program has been worked out with all agencies interested in the general welfare of children.

UTAH

State agency: Board of Health, Crippled Children's Service.

The Crippled Children's Service of Utah established within the fiscal year 1938 medical-social service for all crippled children cared for under the State program. The medical-social worker was added to the staff in February 1938. She acts as the coordinator between the Crippled Children's Service, the State Department of Public Assistance, and the Division of Child-Welfare Services. She interprets to the local workers throughout the State the medical needs of children in relation to social adjustments.

A trained physical therapist was added to the crippled children's staff and is permanently located in a center established for this purpose in Salt Lake City. The physical therapist carries out the recommendations and orders given to her by the physicians attending crippled children's cases and also interprets the special instructions for treatment recommended by the physicians to the parents and guardians of the crippled children. A second center was established in Ogden, so that the physical therapist may check on patients who have been given previous treatment. These two centers are located in counties that contain one-third of the population of the State.

Excellent cooperation has been established between the boards of education and the Crippled Children's Service regarding the transfer of children who are of school age when it is necessary to make arrangements for them to attend school in other counties.

Many changes were made in record keeping, especially in revising the system for setting up the State register.

Intake and discharge services for children under care were set up on a much more adequate basis. All crippled children admitted to the service must be immunized for diphtheria and vaccinated for smallpox must and have a nose and throat culture taken. A complete examination by a physician must be made before hospitalization is authorized.

Physicians are to notify the Crippled Children's Service 3 days in advance when a child is to be discharged from a hospital. A time limit on all hospital cases has become mandatory, the maximum period being 3 months, but hospitalization may be extended upon authorization of the State agency.

At the end of the year the Crippled Children's Service was planning a program on prevention in which the State medical profession was cooperating. Together they were to set up an educational program for physicians and all interested agencies participating in work relative to prevention of crippling deformities.

VERMONT

State agency: Department of Public Health, Crippled Children's Division.

The Crippled Children's Division is an outgrowth of the infantile-paralysis aftercare division which was organized in 1914 following the most severe epidemic that the State has experienced. Although the work was supported privately during the first 19 years and by State funds after that period, the work since its beginning has been carried on as a part of the program of the State Department of Public Health.

This long experience, uninterrupted except for a few months during the World War, served to build up a program that was readily adaptable to the broader service possible with the use of Federal funds. When these additional funds became available, the program was enlarged to include all types of crippling conditions instead of infantile-paralysis cases only. Previous to that time children with all types of orthopedic defects were admitted to the clinics for diagnosis and advice, but if the treatment necessitated an expenditure of funds for braces, hospitalization, or the like, the necessary funds had to be obtained elsewhere.

The major features of the present program are:

1. Locating of crippled children (accomplished mostly through referrals by physicians, public-health nurses, social agencies, interested individuals, and self-application).
2. Follow-up care of patients with acute infantile paralysis in their homes in conjunction with the physician in charge of the case.
3. Diagnostic and follow-up clinics.
4. Surgical care.
5. Postoperative follow-up care.
6. Supplying of apparatus when necessary.
7. Social study and treatment when indicated.
8. Cooperation with the Vocational Rehabilitation Division of the State Department of Education and other agencies providing various types of services which are necessary and helpful in carrying out the program.
9. Occupational therapy for special cases.

Enlargement of the staff to include another part-time orthopedic surgeon, an additional nurse-physiotherapist, a medical-social worker, and another secretary has made possible an extension of the services available to crippled children.

During the fiscal year 1938 an increase occurred in clinic attendance, although the number of State clinics did not increase.

Clinic facilities have improved since the appointment of a professor of orthopedic surgery at the Medical College of the University of Vermont. Six diagnostic and six surgical clinics are held at the Mary Fletcher Hospital during the school year.

More muscle transplantations and surgical work for correction of deformities to eliminate the use of braces have been carried out during the past year.

The organization of the Vocational Rehabilitation Division has been a great help to the program. Patients under the care of the Division have felt that there is a better-defined goal to strive for, knowing that there is a possibility of vocational training if they cooperate in trying to lessen their physical handicaps. Close cooperation exists between the rehabilitation director and the Crippled Children's Division. There is continual interchange of referrals and of medical and social information.

VIRGINIA

State agency: Department of Health, Crippled Children's Bureau.

Every possible private and official agency operating in the State has been utilized to locate crippled children. At the close of the fiscal year 1938, 47 Virginia counties had full-time medically directed health services and 12 counties had nursing service. In those 59 counties the responsibility for work with crippled children had been placed on the local health workers, and excellent cooperation had been developed. They not only search for and find crippled children but they also arrange for and do preliminary visiting for the clinics. They also arrange for and operate the clinics and do the follow-up work. A complete report of each hospital discharge is forwarded to these workers and they make the necessary follow-up visits to see that the aftercare recommended by the orthopedic surgeon is carried out. A copy of each hospital-discharge record is also sent to the family physician. Local workers also arrange transportation of children to and from the hospitals.

In the remaining 41 counties not covered by health workers, all work pertaining to crippled children's clinics and hospital discharges was carried out by the 3 orthopedic nurses attached to the State Department of Health. In addition to these duties they act as instructors to the other public-health nurses throughout the State.

Each county in the State has a county department of public welfare with a trained social worker in charge. These county departments have been very cooperative and have been of great assistance to the Crippled Children's Bureau in locating and helping to care for and transport crippled children.

The State Board of Education through the Division of Rehabilitation has cooperated closely in the program, and through it a State-wide school survey was conducted. Many unreported cases were brought to light through this survey. The Bureau of Communicable Diseases in the State Department of Health has been very cooperative in reporting promptly all cases of infantile paralysis. This has enabled the Crippled Children's Bureau to give early orthopedic consultation and in many cases prompt hospitalization during the acute or sub-acute stages of the disease.

The 16 orthopedic surgeons comprising the State Orthopedic Society are affiliated in the Bureau's clinic service. As of June 30, 1938, there were 43 permanent and 2 itinerant clinics. Clinic attendance during the year was 3,884. Clinic rooms, equipment, and technique have gradually been improved. Effort has been made to place these clinics on a consultation basis, and the family physicians of all patients were encouraged to attend the clinics and discuss with the clinic surgeon the findings and recommendations relating to their patients.

Beds for 115 white and 35 Negro patients are available in the 2 State-owned general hospitals located at Richmond and Charlottesville for the treatment of orthopedic and plastic cases. Ten beds are available at Jefferson Hospital in Roanoke.

WASHINGTON

State agency: Department of Social Security, Division for Children.

At the beginning of the fiscal year 1938 the crippled children's program of the State Department of Social Security was decentralized and was developed in the four hospital centers in Seattle, Tacoma, Bellingham, and Spokane, with a full-time medical-social worker in charge at each center. Her duties toward crippled children between 14 and 21 years of age who are to receive care under the program include (1) responsibility for planning of clinics, (2) distribution of

clinic reports to the agencies concerned, (3) social investigation and determination of eligibility of children referred from the county where the center is located, and (4) supervision of referral to the children's workers in the surrounding counties. Final authorization for beginning treatment and payment for services rendered are still controlled in the State office. This decentralization has made possible closer contacts with the children's workers of the counties sending children to each of the centers, as well as more nearly adequate aftercare services for the children. The orthopedic staff surgeons can interpret their medical findings and recommendations directly to the medical-social worker so that she can then give more concise information to the children's workers and the county public-health nurses, who give public-health-nursing supervision in the homes.

The most noticeable progress in the program is the increase in the number of children seen through clinics and referred for care to the crippled children's program. Because 4 private orthopedic units in Washington have given excellent medical care to children from birth to 14 years of age, it was thought that within a 2-year period most of the children from 14 to 21 years of age—the age group cared for in this State under the crippled children's program—who were in need of orthopedic care would be located and treated under the State program. It was found, however, in 1938, that 785 children were examined in the State clinics as compared with a total of 660 in the 1936 clinics. An average of 130 children received care each month during 1938, whereas only 85 children per month received care in 1937. This increase in the number of crippled children located may be attributed largely to the fact that there are now public-health nurses in all counties of the State and child-welfare workers in each county welfare department. Coupled with these causes is the routine establishment of referrals, from the private orthopedic units, of children who have reached their fourteenth birthday and are in need of continued orthopedic service.

The medical service given in the clinics has been improved through the addition of a pediatrician to each clinic staff. A psychologist has been added to the State staff of the Division for Children. His services have likewise been made available at the diagnostic clinics.

In Seattle the Swedish Hospital, a privately owned hospital, built an entirely new wing for crippled children, consisting of 30 beds and complete physical-therapy equipment, including a large pool, a classroom, and an office for the medical-social worker. Much in the way of education and handicraft has been made possible through this hospital unit. The medical-social worker has been able to work with many local groups in behalf of these children. The Rotary Club has provided transportation to and from the hospital, the auxiliary of the Veterans of Foreign Wars has provided handicraft materials, the city school board has sent a full-time teacher to the unit and the foster homes, and the Works Progress Administration has provided a full-time handicraft instructor.

Similar programs are found in each of the other hospital centers.

During 1938, with medical-social workers in the 4 centers, it was possible to place children in foster convalescent homes when they needed out-patient physical therapy or were in a cast, but were not in need of hospital care. Twelve foster convalescent homes are in use in the hospital centers. Two of the homes are operated by graduate nurses. Children needing changes of dressings or children in casts are sent into these two homes; only ambulatory cases are sent to the other foster homes.

During 1938, 142 children treated under the crippled children's program were referred for training to the Vocational Rehabilitation Division of the State

Department of Education. For 23 of this number the training continued into the fiscal year 1939. Six children placed in training late in 1936 have obtained private employment as stenographers or watch repairers.

In 1934 a survey of physically handicapped children was made under the direction of the State Department of Health. Three hundred and thirty-four of the children located in the survey have received some form of service through the crippled children's program. At each clinic additional cases found in the survey are brought in. Three of the private orthopedic units are providing monthly State registry cards for children under 14 years of age receiving orthopedic service.

WEST VIRGINIA

State agency: Department of Public Assistance, Division of Crippled Children.

Provision for consultation services other than orthopedic has been made by arranging to pay consultation fees for medical relief on the basis prescribed by the Department of Public Assistance.

The educational program for the staff has been improved by school and in-service training. In-service training has included State convention programs, lectures by State orthopedists, and conferences held by the nursing staff. Clinics have been used as demonstration centers.

The method of locating crippled children has been improved through the cooperation of the county units in assisting in the location and reporting of crippled children. The method of having the county units clear the cases has proved most satisfactory, as it has centralized the intake service.

The permanent register book in each clinic has provided additional detailed information. Index clinic cards are now used in all clinics. The information on these cards is available in cases where there is any question as to status and assignment to clinic orthopedist and hospital. This has given invaluable assistance, as the State workers and nurses are not familiar with the cases in all districts.

The organization of clinic service has been improved. The use of clinic orders and turning over the arrangements for transportation to the county units of the Department of Public Assistance has eliminated duplication and unnecessary work. A standard procedure is used in all clinics.

Hospitalization services have been much improved by the addition of more bed space, the employment of trained nursing supervisors, and the provision made in some hospitals for physical therapy for State cases.

A case summary giving complete social history and financial standing must be furnished for every case submitted to the Department for authorization.

Convalescent-home care has been improved by the addition of two new buildings at two of the convalescent homes. All members of the nursing staff are qualified, and each supervisor is a graduate nurse.

Foster-home care has been more closely supervised by the medical-social worker and the nursing supervisor.

The educational and vocational program has been so organized as to give better service to a larger number of children.

An attempt has been made to coordinate the activities of the county departments of public assistance, the Division of Child-Welfare Services, and the Division of Crippled Children. A graduate registered nurse qualified in orthopedic nursing, with public-health experience, is supervisor of nursing.

A State physical-therapy technician has been added and a definite plan for services has been worked out.

A medical-social worker was also added to the staff during 1938.

WISCONSIN

State agency: Interdepartmental Committee on Services for Crippled Children, Crippled Children's Division, State Department of Public Instruction. (Now State Department of Public Instruction, Bureau for Handicapped Children, Crippled Children's Division.)

The Crippled Children's Division, functioning as part of the State Department of Public Instruction under the Interdepartmental Committee on Services for Crippled Children, has combined, under the supervision of one State agency, a concurrent program for the physical restoration and the education of crippled children. In order to provide centers for carrying on this combined program, orthopedic schools have been established in 11 cities in the State; one of these schools was established during the fiscal year 1938.

During the year 891 children were served by the orthopedic schools, an increase of 99 over the preceding year. These schools serve a twofold purpose: (1) To provide special building facilities for the children who are too handicapped to attend a regular school, and (2) to provide facilities for physical therapy and supervision for children for whom medical recommendation has been made for such care. All children come to the orthopedic schools with medical recommendations. Those for whom treatment has been recommended are served by the physical-therapy departments of the schools until their physician feels they have obtained maximum improvement from such care. If these children are able to attend their regular school with safety and comfort, they do so. If they cannot, they remain in the academic classes of the orthopedic school until they complete the elementary grades.

Children dismissed from the orthopedic schools, however, remain under the active supervision of the Crippled Children's Division until their disability is corrected or until they reach the age of 21. This Division also has supervision of the educational program for all crippled children during the elementary and high-school period whether they are under supervision of orthopedic schools, hospital classes, or regular schools.

To supplement the educational facilities available in the public-school system, the Crippled Children's Division has established academic classes in three children's hospitals in this State, so that children who are confined to these hospitals for long-time orthopedic care may continue their academic education.

It was found necessary this past year to expand certain phases of the program to meet the emergency resulting from the large number of poliomyelitis cases in two sections of the State. One of these sections was the city and county of Milwaukee and the other the territory surrounding the city of Eau Claire. The Crippled Children's Division, with the approval and cooperation of the Eau Claire County Medical Society and the councilor to the Wisconsin State Medical Society from that section of the State, established a convalescent center in a hospital in Eau Claire. Arrangements were made for the hospitalization of 14 children. Physical therapy was provided by a member of the field staff of the Crippled Children's Division. The county medical society invited an orthopedic specialist to come to Eau Claire at periodic intervals for examination and care of patients. A local pediatrician was designated by the county society to provide the necessary general medical supervision. Academic instruction was provided during the several months that this convalescent-care program was continued in the hospital, until the children could be transferred to the orthopedic school. They were then placed in various private homes and were transported each day to the orthopedic school where the physical-therapy care was continued.

During the summer months the physical-therapy service was continued at the orthopedic schools located in Eau Claire, Kenosha, Madison, Milwaukee, and West Allis to provide care for recent cases of poliomyelitis during the summer period when the orthopedic schools are usually closed.

During the past fiscal year public-health-nursing service was established or renewed in a number of counties. For those counties the Crippled Children's Division furnished detailed information regarding crippled children residing in those areas, including a summary of the last medical recommendation which had been made for each child.

There has been an increasing interrelationship between the work carried on by the Crippled Children's Division and public-health services throughout the State.

WYOMING

State agency: Board of Health, Division for Crippled Children.

The major features of the Wyoming program for crippled children are:

1. The finding of crippled children.
2. The maintenance of a State register of all crippled children.
3. The provision of diagnostic facilities for orthopedic and plastic cases.
4. Provision of facilities for the correction of orthopedic and plastic defects, if the parents are unable to afford all or part of the cost of such care.
5. Provision of aftercare services on a State-wide basis for children who have been operated on, who have been given braces, or for whom physical therapy has been prescribed.
6. Cooperation, especially with the education and welfare departments, in working out plans for the general welfare of the crippled child.

Progress during the fiscal year 1938 was made in connection with each of these features as follows:

1. Case finding was improved through—
 - (a) Referral of others by satisfied patients.
 - (b) Improved publicity in relation to orthopedic conferences.
 - (c) Increased referrals from local physicians as a result of better understanding and cooperation.
 - (d) Increased referrals from Shrine and other service clubs.
2. A card was devised for the State register listing only those items requested on the memorandum issued by the United States Children's Bureau on April 5, 1938.

When a child's name is placed on the State register, or has been reported for registration but his eligibility has not been determined, a card is filed in the county file and a referral card is placed in the general file in which are listed all children who have ever been referred to the Division for Crippled Children. At the end of each quarter the director and assistant director go over all the cards in the county file, making such changes as are needed.

3. Diagnostic clinics were held in 10 towns (5 clinic districts). Each was conducted by an orthopedic surgeon who is a diplomate of the American Board of Orthopedic Surgery. General examinations were usually made by the local county health officer. Assistance was given by the director and assistant director of the State Division for Crippled Children, by one or more of the public-health nurses working under the Division of Maternal and Child Health, and by local volunteers.

When cases were reported to be needing immediate orthopedic examination, provision was made for such an examination in the office of the nearest orthopedic surgeon.

4. Financial aid was offered both to charity and to part-pay cases. When necessary, transportation was furnished. Some plastic as well as orthopedic cases were cared for this year. Sufficient funds were available to offer aid to all cases coming within the State definition of a crippled child. Hospitalization was provided for all patients needing it.

5. Aftercare services were improved through—

(a) An increase in the number of home visits.

(b) Improved follow-up in those counties where local nurses were working, as a result of the revision in the form used and of individual instruction given to public-health nurses.

6. The head of the Division of Vocational Rehabilitation was invited to all orthopedic conferences. Following conferences cases needing either vocational rehabilitation or special education in the home were discussed with the proper persons in the education department, who, in turn, brought to the Division for Crippled Children problems related to handicapped children referred to them from other sources.

Appendix.—Text of the Sections of the Social Security Act Relating to Grants to States for Services for Crippled Children, as Amended by the Social Security Act Amendments of 1939¹

[Original law printed in roman; new law printed in *italics*]

Title V.—GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

* * * * *

Part 2.—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

Sec. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of \$3,870,000.² The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 512. (a) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State \$20,000, and \$1,830,000³ to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

(b) *Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to the States \$1,000,000 (in addition to the allotments made under subsection (a)), according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.*⁴

(c) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

¹ 49 Stat. 629; 53 Stat. 1360.

² \$2,850,000 in the law as enacted in 1935.

³ "The remainder" [\$1,830,000] in the law as enacted in 1935.

⁴ This section was added by the amendments of 1939.

APPROVAL OF STATE PLANS

Sec. 513. (a) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board⁵ shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods)⁶ as are necessary for the *proper and*⁷ efficient operation of the plan; (4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for carrying out the purposes specified in section 511; and (6) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

Sec. 514. (a) From the sums appropriated therefor and the allotments available under section 512 (a), the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for

⁵ This reference to "the Board" appears to have been made inadvertently, as uniform amendments to several titles of the act were being considered by the Conference Committee of the two Houses of Congress. It should be construed as if it read, "the Chief of the Children's Bureau."

⁶ "Other than those relating to selection, tenure of office, and compensation of personnel" in the law as enacted in 1935.

⁷ Added by the amendments of 1939.

any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(c) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotment available under section 512 (b), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department, and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.⁸

OPERATION OF STATE PLANS

Sec. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

* * * * *

Part 5.—ADMINISTRATION

Sec. 541. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of \$425,000,⁹ for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531.

(b) The Children's Bureau shall make such studies and investigations as will promote the efficient administration of this title, except section 531.

(c) The Secretary of Labor shall include in his annual report to Congress a full account of the administration of this title, except section 531.

* * * * *

Title XI.—GENERAL PROVISIONS

DEFINITIONS

Section 1101. (a) When used in this act—

(1) The term "State" (except when used in sec. 531) includes Alaska, Hawaii, and the District of Columbia, *and when used in titles V and VI of such act (including sec. 531) includes Puerto Rico.*¹⁰

⁸ This section was added by the amendments of 1939

⁹ The amount for each fiscal year is determined by Federal appropriation acts.

¹⁰ Added by the amendments of 1939. The amendment (shown in italics) became effective January 1, 1940.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

* * * * *

(d) Nothing in this act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS

Sec. 1102. The Secretary of the Treasury, the Secretary of Labor, and the Social Security Board, respectively, shall make and publish such rules and regulations, not inconsistent with this act, as may be necessary to the efficient administration of the functions with which each is charged under this act.

SEPARABILITY

Sec. 1103. If any provision of this act, or the application thereof to any person or circumstance, is held invalid, the remainder of the act, and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

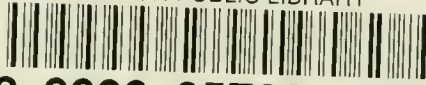
Sec. 1104. The right to alter, amend, or repeal any provision of this act is hereby reserved to the Congress.

SHORT TITLE

Sec. 1105. This act may be cited as the "Social Security Act."



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